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In the Supreme Court of the United States

OCTOBER TERM, 1983

AMERICAN FAMILY LIFE ASSURANCE CO.,
PETITIONER,

v.

MICHAEL SABBAGH,
COMMISSIONER OF INSURANCE
RESPONDENT.

Petition for a Writ of Certiorari to the Massachusetts Supreme Judicial Court.

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Questions Presented

1. Did the decision of the highest court of Massachusetts deny the petitioner the right to effectively challenge the constitutionality of a State Regulation as being in violation of the Fourteenth Amendment?

2. Did the Highest Court of Massachusetts err in not considering 'special facts' found by a trial court were sufficient to invalidate a state regulation under the due process clause Fourteenth Amendment?

3. Did the application of the contested regulation to the petitioner deprive it of a 'property interest' without due process of law?

4. Is the contested regulation arbitrary, capricious and unreasonable, and, therefore, in violation of the Fourteenth Amendment?

5. Is a state regulation entitled to the same presumption of regularity as a statute under the Fourteenth Amendment?

6. Was the petitioner denied the equal protection of the laws and due process under the Fourteenth Amendment by certain evidentiary and/or procedural requirements of Massachusetts?

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RESPONDENT.

Petition for a Writ of Certiorari to the Massachusetts Supreme Judicial Court.

Introduction

The petitioner, American Family Life Assurance Co., respectfully prays that a writ of certiorari issue to review the judgment and opinion of the Massachusetts Supreme Judicial Court entered on March 15, 1983.

Opinions Below

The opinion of the Superior Court, Suffolk County finding for the petitioner (Appendix A, *infra*, pp. 1-55) is unreported. The opinion of the Supreme Judicial Court of Massachusetts (Appendix B, *infra*, pp. 1-14) is reported in 446 N.E. 2d 1061.

[1] Another party to this action, not named, and not appealing herein is Union Fidelity Life Insurance Company.

Jurisdiction

1. The judgment of the Supreme Judicial Court was entered on March 15, 1983 (*see*, 446 N.E. 2d 1061) holding that a state insurance regulation is valid and constitutional. The judgment is final by its terms.

2. In the complaints and throughout the proceedings in the state courts, the petitioners raised the federal questions. (*See* Appendix A & B).

3. On June 3, 1983, Mr. Justice Brennan extended the time for filing petition for writ of certiorari to and including July 28, 1983.

4. The jurisdiction of this court is invoked under the provisions of 28 U.S.C., § 1257(3).

Constitutional and Statutory Provisions

The Fourteenth Amendment to the Constitution of the United States provides in Section 1 as follows: "All persons born or naturalized in the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of the citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

The relevant portions of 211 Code Massachusetts Regulations 47.07(1)(a)-(e), 47.09(4)(a)-(c) (1980), ch. 175, §§ 110E, 108 are set out in full in the text of the Petition and Appendix A.

Statement of the Case

A. *Facts*

In 1973 the Massachusetts legislature enacted Chapter 1081 of the Acts of 1973 authorizing the Commissioner to make rules and regulations with respect to individual health and accident policies. The body of the Act is found in G.L. c. 175, § 110E, the first paragraph of which reads as follows:

> The Commissioner shall make rules and regulations . . . to establish minimum standards of full and fair disclosure, for the form and content of policies of accident and sickness insurance . . . such rules shall apply to all, any portion or reasonable classifications of such policies or contracts, and shall be made to bring about:
> (a) reasonable standardization and simplification of coverage to facilitate understanding and comparisons;
> (b) elimination of provisions which may be misleading or unreasonably confusing, in connection either with the purchase of such insurance or with the settlement of claims;
> (c) elimination of deceptive practices in connection with the sale of such insurance;
> (d) elimination of provisions which may be contrary to the health care needs of the public;
> (e) elimination of coverage which are so limited in scope as to be of no substantial economic value to the holders thereof.

The fifth paragraph of Section 110E, relative to the promulgation of agency rules and regulations under the authority of 110E, reads as follows:

> Rules and regulations made pursuant to the authority of this section shall be adopted in accordance with the procedures of section two of chapter thirty A and shall be subject to review as set forth therein.

The statute further provides that the Commissioner may

withdraw his approval of any previously certified policy forms not found to be in compliance with regulations issued under section 110E, apparently without providing for an adjudicatory hearing and a right of judicial review. The second paragraph of section 110E reads as follows:

> When a rule or regulation has been adopted pursuant to this section and an individual policy of accident and sickness insurance form regulated by section one hundred and eight is not in compliance with such rule or regulation, such non-compliance shall be grounds for a withdrawal of approval of such policy form and the commissioner may withdraw his approval of any such form upon written notice to the insurer specifying his reasons therefore.

Chapter 1081 was approved on November 26, 1973. The Governor's emergency declaration was filed on November 27, 1973.

In the fall of 1974 Commissioner Ryan of the Division of Insurance promulgated a regulation entitled "Rules and Regulations Establishing Minimum Standards of Full and Fair Disclosure for the Form and Content of Accident and Sickness Insurance sold in the Commonwealth of Massachusetts". It was designated Regulation 2-74 and later codified as 211 CMR 42. (Regulation 2-74 was the first regulation promulgated to implement the provisions of the newly enacted G.L. c. 175, § 110E, added by Chapter 1081 of the Acts of 1973 during Commissioner Ryan's term of office. It was also the first regulation governing accident and health policies since the enactment of G.L. c. 175, § 108 in 1949.

The adoption of the regulation followed a notice of public hearing dated March 22, 1974, the distribution of a 15-page packet of the proposed rules and regulations, and a public hearing held on April 24, 1974.

Section 1 of Regulation 42 indicated that the document applied to "individual accident and sickness insurance policies."

Section 12 of the Regulation made reference to insurance policies which are written to provide coverage for specified illnesses or accidental injuries. (Sometimes called 'specific disease' policies, or 'dread disease policies'). The section read as follows:

> *Specified Disease or Specified Accident Coverage* Specified disease or specified accident coverage provides coverage which is limited to a delineated or defined field of sickness coverage, such as poliomyelitis, cancer, dental services, or a specifically named or described disease or to a delineated or defined type of accident, such as an automobile accident or trip accident which, in the case of disease, has a maximum limit of no less than $10,000 and which in the case of an accident, provides amounts as least as great as those provided in Section 5.

Quite apart from whether Regulation 42 expressly or by implication exempted previously approved policies from compliance with its terms, the policy review section of the Division treated them as exempt. It was the view of the Division that they had been 'grandfathered' by Regulation 42.

Regulation 47 On September 27, 1979 Commissioner Sabbagh promulgated a regulation entitled "Rules and Regulations Governing Individual Accident and Sickness Insurance", later codified as 211 CMR 47.00

At the same time a document was filed with the Secretary of State which amended the previously adopted 211 CMR 42.00 by repealing Section 211 CMR 42.05(19) and 42.05(20), by striking out Section 211 CMR 42.12, and by inserting in place of 42.12 a new Section 42.12 entitled "Specified Disease or Specified Accident Coverage". For purposes relevant to this case, such amendments and substitutions replaced the summary description of specified disease and specified accident coverage as it formerly appeared in 42.12 with the new and enlarged definition for specified disease coverage and a new definition of specified accident coverage. The

new definition of specified disease coverage is now found in Regulation 47.07(1).

Regulation 47 touches upon many subjects, such as readability standards, medicare supplement insurance, disclosure provisions, standard forms, etc.; but insofar as the issues now under litigation are governed it drastically altered and enlarged the government's involvement in the regulation of individual policies for specified disease coverage.

In effect, the 1979 regulation removed the definition of specified disease coverage from the former Regulation 42 by referring the public to the new specified disease regulations embodied in Regulation 47. Section 42.12 of the former regulation, as amended, now reads as follows:

> 42.12 'Specified disease coverage' provides coverage as defined in 211 CMR 47.07(1).

The new Section 47.07(1) reads as follows:

> (1) *Specified Disease Coverage*
>
> (a) "Specified disease coverage: has a maximum benefit limit of no less than $10,000 and provides benefits for all of the following specifically named or described conditions:
>
> 1. Cancer in any of its manifestations.
>
> 2. Severe extensive disabling burns and contractures due to burns.
>
> 3. Disabling paralysis of extremities due to inflammation, degeneration, or other benign lesion of the central nervous system.
>
> 4. Disabling major bone fractures, bone fusions, joint dislocations, joint fusions, and limb amputations.
>
> 5. Acute infraction of the heart and chronic disabling congestive heart failure.
>
> 6. Chronic ulcerative colitis and chronic regional enteritis.
>
> 7. Chronic tuberculosis and chronic osteomyelitis.
>
> 8. Chronic rheumatoid arthritis, chronic rheumatic fever, chronic chorea, chronic disseminated lupus erthematosus, chronic periarteritis, or other chronic collagen or systemic sensitivity.

9. Addison's disease, pituitary disorders, or other major endocrinopathies, but not including diabetes.

10. Chronic severe or totally disabling pulmonary insufficiency.

11. Chronic hemolytic anemia, chronic aplastic anemia, chronic toxic anemia and other chronic bleeding disorders requiring continuing therapy, but not including iron deficiency or blood loss anemia.

12. Chronic nephrosis, chronic nephritis, and cystic fibrosis.

The conditions must be verified conclusively by biopsy, x-ray examinations, laboratory determinations, or if an external defect, by unequivocal observation.

(b) Internal limits on dollar benefits can be no less than the following:

1. Room and board daily benefits in semi-private accommodations of at least $150 per day or charges, whichever is the lower, for at least 60 days of continuous hospital confinement.

2. All other scheduled benefits must provide a benefit maximum of at least 10% of the total aggregate maximum benefits.

(c) Specified Disease Coverage shall be guaranteed renewable, as defined in 211 CMR 47.09(4)(c), to age 65 or to the date a person on Social Security disability, or age 65, is insured under Medicare A and B, and a Massachusetts Medicare Supplemental Policy. Specified Disease Policy Coverage may not be sold to anyone over age 65.

(d) Specified Disease Coverage may be sold only as a supplement to Basic Hospital Insurance as defined in 211 CMR 42.07. The benefits shall begin when the coverage in the Basic Policy is exhausted.

(e) Any policy covering specified diseases must meet the standards of 211 CMR 47.07(1)(a) through 47.07(1)(d); it may not be sold as Restricted Health Insurance as defined in 211 CMR 42.13.

19. The documents indicate that the new regulation was promulgated under the authority of G.L. c. 175, §§ 2B, 108 and 110E; c. 176, § 26; c. 176AA; c. 176B; and c. 176E.

By its terms, Regulation 47 was to become effective upon publication (211 CMR 47.03). The date of its publication was September 27, 1979.

In the event of conflict between the provisions of Regulation 42 and Regulation 47, the latter was to govern. Subsection 211 CMR 47.02 reads as follows:

> *47.02: Applicability and Scope*
>
> This regulation shall apply to all individual accident and sickness insurance policies and to non-group subscriber contracts of non-profit hospital, medical, and dental service corporations filed with the Division of Insurance, delivered, or issued for delivery after the effective dates of this regulation, except group conversion policies or contracts. Health Maintenance Organizations are exempted from 211 CMR 47.07 and following. No policy or contract covered by this regulation shall be issued or issued for delivery unless it complies with this regulation. This regulation supplements the rules of 211 CMR 40.009 through 42.00; in case of direct conflict between this and earlier regulations, this regulation shall govern.

In a literal sense, once 211 CMR 47.07(1) became law it was no longer possible to market specific disease policies in Massachusetts under Regulation 47 unless the policy provided coverage of at least $10,000, nor unless it covered all 12 categories of disease or illness listed in subsection (a), nor unless it covered actual daily costs up to $150 a day for at least 60 days, nor unless it provided a benefit maximum of at least 10% of the total maximum benefits for all other scheduled benefits, nor unless it was guaranteed as renewable at age 65, nor unless it was sold only to persons under the age of 65, nor unless it was sold only as a supplement to a basic hospital insurance policy. In short, the new specifications were most rigorous and exacting, to the point as will be discussed below that any future sales of specific disease policies were perhaps no longer commercially practicable or possible in Massachusetts.

Whether the draftsmen of Regulation 47 intended it to have both prospective and retroactive effect, or prospective effect only, is difficult to resolve from the text itself. 211 CRM 47.02 states that "This regulation shall apply to all . . . policies . . . filed with the Division of Insurance, delivered, or issued for delivery after the effective dates of this regulation . . ." This language parallels similar language in Sections 4 and 25 of Regulation 42, under which the Commissioner regards previously approved policies as having been 'grandfathered'. 211 CMR 47.02 goes on to say, however, that "No policy or contract covered by this regulation shall be issued, or issued for delivery unless it complies with this regulation" and that "in case of direct conflict between this and earlier regulations, this regulation shall govern." For lack of a clear savings clause in Regulation 47 to salvage previously approved policies, the Commissioner has deemed Regulation 47 to have retroactive effect.

In the trial for the Massachusetts courts the petitioner American Family Life Assurance Company was joined in this action by another insurance company, similarly situated, namely Union Fidelity Life Insurance Company of Trovous, Pennsylvania, also an insurance company licensed to do business in the Commonwealth and authorized to sell accident and sickness insurance in the Commonwealth by its laws.

Previously Approved Policies During the trial of their actions in the trial court, the petitioners furnished evidence of specified disease policies issued by their companies before Regulation 47 took effect which had either been approved by the Commissioner or which had been deemed to be approved.

On April 22, 1974, prior to the adoption of either Regulation 42 or 47, *American* submitted a cancer policy to the Division of Insurance for approval under G.L. c. 175, § 108. The form (No. 6021) was approved by the Division for issuance and delivery by letter dated April 25, 1974. Since it antedated

both regulations it could lawfully be marketed in the Commonwealth of Massachusetts as approved, subject only to the provisions of G.L. c. 175, § 108. The Commissioner could not bar such a sale except by giving notice of his withdrawal of approval and by holding the necessary hearing under subsection 8B of section 108.

After the adoption of Regulation 42 in late 1974 but prior to the enactment of Regulation 47, *American* obtained approval for the sale of another cancer insurance policy. On December 12, 1976 the company submitted its policy form A-8011 to the Division of Insurance for approval, and by letter dated January 6, 1977 the company was notified that policy form A-8011 was "deemed approved". It was the policy of the department to issue a "deemer" letter upon request in any case where the department had not issued its disapproval under Sec. 108, notwithstanding the department's awareness that an approval by default was a matter of law and that a confirmation letter was not required by statute.

American's policies A-6021 and A-8011 were both accident and sickness policies within the meaning of G.L. c. 175, § 47, paragraph 6. In addition, since both policies cover persons for the specified disease of cancer, they are properly classified "specified disease policies" as defined by Section 12 of Regulation 42. They will be referred to herein as "specified disease" policies without prejudice to the contention of *American* that they are not subject to the current specified disease provisions of Regulations 42 and 47.

At the time it was filed and approved by default, American's policy form A-8011 did not comply with all of the provisions of Regulation 42. It was not non-cancelable for life without right to raise the premium rate. (*See* 211 CMR 42.05(32). It was guaranteed renewable, but it did say that the policy rates could be increased with approval of the Division. Notwithstanding its non-compliance the policy could lawfully be sold in the Commonwealth under G.L. c. 175, § 108.

The Commissioner could bar such sale only by giving notice of withdrawal of approval and by holding the required hearing under G.L. c. 175, § 108.

After 1973 approximately thirty insurance companies who were licensed to sell health insurance in Massachusetts issued dread disease policies for such illnesses as cancer, heart disease, and leukemia.

Prior to 1973 the department had approved other policy forms which had been submitted by American Family Life, Mutual of Omaha, Union Fidelity and National Home Life.

Since July 1, 1978 no further approvals of specified disease policies have been granted for lack of compliance with either the readability law (not relevant to this appeal) or Regulation 47, or both. As for disapprovals, there have been two, each with respect to an effort by the Physicians Mutual Insurance Co. to add a chemotherapy rider to a previously approved basic hospital insurance policy at no further cost to the policy holder. The two requests for approval, one dated June 24, 1980 and the other dated July 21, 1980, were both rejected by the department for non-compliance with Regulation 47. They failed to comply, among other reasons, for not including all twelve dread diseases listed in 211 CMR 47.07(1).

B. *Proceedings Below*

The petitioner brought an "Amended Petition for Declaratory Relief" challenging Regulation 47 (another company also brought a petition in the matter and they were tried together). The Petition challenged the validity of the regulation on its face, in practice,and the constitutionality of the regulation as applied to it and others similarly situated. It claimed that the regulation was unreasonable, arbitrary and capricious and therefore invalid and unenforceable. It challenged the constitutionality of the regulation under the Federal and State Constitutions, attacking the validity of the regulation

under the due process and equal protection clauses of the United States Constitution.

In accordance with procedures set forth in a series of Massachusetts cases, the trial was held before the Superior Court of the State (hereinafter referred to as the Trial Court.) *Massachusetts State Pharmaceutical Association v. Rate Setting Commission*, 387 Mass. 122, 126 (1982). The trial was conducted strictly in accordance with the rules promulgated by the highest court of the state. The evidence taken was for the most part uncontradicted. The lower court judge rendered a decision in judgment invalidating the regulation as both unlawful and unconstitutional.

In conducting the trial, the challengers of the regulation were limited to and could not use the hearing record before the Agency to prove their challenge. The trial judge made findings of fact on evidence. He also reviewed the surface validity of the regulation, *i.e.*, looking at the regulation as if it were a statute based on the applicable "legislative" facts.

In determining that the regulation was substantively unconstitutional, *i.e.*, "arbitrary, capricious, and unreasonable", the trial court applied the following standards to those words:

> The manner in which a statute seeks to carry out the purpose of the legislative intent must be reasonable. It is seriously in question if found in any sense to be arbitrary, capricious, or unreasonable. The means selected to achieve the statutory purpose must have a real and substantial relationship to the object sought to be attained. (citations omitted).
>
> Although terms such as unreasonable, arbitrary, and capricious are generic rather than specific, and for that reason may seem to be unworkable as standards for judicial review, this is not the case. They have well settled common law meanings and have been a part of our jurisprudence for a long period of time. When employed as standards of judicial review, their meaning and application can be elicited and safely resolved on the facts of

the particular case. (citation omitted). (Appendix A. pp. 33-34)

Applying the standards described, the trial judge made "special findings of fact" concerning each of the issues raised by the Petitioner in attacking the substantive and procedural constitutionality of and the validity of the regulation. These special findings of fact appeared before his conclusions on each of the contested issues.

The trial court, in its decision, rendered opinions concerning the surface validity of the challenged regulations as follows:

1. To the contention that regulation 47.07(1) exceeded the scope and purposes of its parent statutes, the court after analysis found as follows:

> 96. In the judgment of the court, 211 CRM 40.07(1) of regulation 47, insofar as it permits the Commissioner to condemn specified disease policies which are not in compliance with the terms of the subsection, yet without making any provisions for a right of protest, a right to be heard and a right of judicial review, appears to overflow the bounds of section 108 and to have no rational relationship to any relevant statutory purpose. (Appendix A, p. 40)

2. In response to the contentions of the plaintiffs that G.L. c. 175, § 110E did not authorize regulations which withdraw approval of accident and sickness policies previously valid for sale under G.L. c. 175, § 108, without first granting an adjudicatory hearing and a right of judicial review, the court, after analysis, declared as follows:

> 131. In the judgment of the court section 110E, c. 175 should not be read as overriding the express grants of due process rights set forth in section 108, subsections (2)(a) and 8A,B,C . . . (Appendix A, p. 53)
>
> 133. It is the further judgment of the court that the Commissioner is unwarranted in holding that previously approved health and accident policies, which do not com-

> ply with the requirements of a section 110E regulation such as regulation 47 in this instant, may be condemned for further sale or use without first offering the effected insurer the due process right spelled out in section 108, and that any action he may have taken thus far to revoke the good standing of such policies would do violence to rights of constitutional due process and should be declared null and void. (Appendix A, p. 54)
>
> 136. . . . Neither section 110E, nor section 2B should be construed as abrogating, by implication, an insurers due process rights to notice, to a hearing and to judicial reviews as spelled out in section 108. (Appendix A, p. 55)

3. As to the contention of the plaintiffs that section 47.09(4), which states that any rates schedule filed with the Division will be disapproved, unless the anticipated loss ratio filed with the rate schedule under 47.09(3) meet certain minimum percentage requirements, the court after analysis, (Appendix A, p. 69) found as follows:

> 181. In the judgment of the court and for the reasons outlined in preceding portions of this opinion, relative to the validity of 211 CMR 47.07(1), 211 CMR 47.09(4) exceeds the regulatory power of the Commissioner. (It is) in conflict with the provisions of section 108 which entitle an insurer to an adjudicatory hearing and a right of judicial review in any case where a withdrawal of a prior approval was attempted. (Appendix A, p. 70)

After determining that regulation 211 CMR 47.07(1) could only be authorized by subsections (d) and (e) of chapter 175, section 110E, and analyzing the evidence from the point of view that the authority of such sections was not limited by the overriding purpose of "establishing full and fair disclosure", a position most favorable to the Division of Insurance, the Court declared that there appeared to be no rational basis for the twelve (12) disease classifications contained in 211 CMR 47.07(1) as follows:

1. "From an economic or health care standpoint." (Appendix A, p. 26)
2. "From the standpoint of the catastrophic illness test." (Appendix A, p. 27)
3. "From a standpoint of frequency of occurrence." (Appendix A, p. 28)
4. "From the standpoint of medical costs." (Appendix A, p. 28)
5. "From the standpoint of medical security." (Appendix A, p. 29)
6. "From the standpoint of the Commissioner's reliance on Blue Cross/Blue Shield (PIC) as a basis for 47.07(1)(a)." (Appendix A, p. 31)

Looking at the mandatory 12 diseases requirements within the court's findings as to the scope and intent of the statute the trial court found as follows:

> In effect, the mandatory 12 diseases requirement effectively prohibited the sale of single disease policy even though it may otherwise satisfy the basic intent and purpose of the statute, even though it may meet remaining requirements of the regulations . . . (Appendix A, p. 32)
> With all of the foregoing in mind and buttressed by their belief, that regulation 47 reflects a prejudice on the part of the Division against single disease polices 'per se', the petitioners contend that 211 CMR 47.07(1)(a) is arbitrary, capricious and unreasonable as a matter of law. The court agrees.

The trial court further found as follows:

> In conclusion, the petitioners' contention that the provisions of 47.07(1)(d) limiting the sale of specified disease policies to those which supplement a basic hospital insurance policy, particularly when made subject to the other stringent requirements of 47.07(1), constitutes an arbitrary, capricious and unreasonable regulation are well founded. The Court agrees. (Appendix A, p. 36)

The Supreme Judicial Court of Massachusetts, the highest court of the state, reversed the trial court. The reversal was

first based on the trial court's interpretation of state law, *i.e.*, the meaning of G.L. c. 175, § 110E, from the statutory history of the act. The Supreme Judicial Court then dealt with the two constitutional issues of substantive and procedural due process that were decided by the trial court.

The plaintiffs had alleged that the regulation on its face and in practice was arbitrary, capricious and unreasonable, and therefore in violation of the due process clause of the federal constitution. The trial court had sustained the plaintiffs in their contentions. The Supreme Judicial Court reversed the trial court stating as follows:

> As a threshold matter, we note that there appears to be some confusion among the parties as to the difference between a challenge to a regulation in practice and on its face, and the proper standards of our review of the Superior Court judgment. The plaintiffs argue that because they produced evidence at trial, they attacked regulation 47.07(1)(a) and (d) as arbitrary and capricious in practice, and we should review the judge's decision under the clearly erroneous standard. If the regulations exceeded the Commissioner's statutory authority, they would then be arbitrary and capricious on their face in that they would by definition be unrelated to the achievement of any statutory goals. Here the judge found that, even assuming the Commissioner was empowered to promulgate the regulation, they were not rationally related to the goals of Sec. 110E. His conclusion was certainly based on evidence the plaintiffs produced at trial. However, this was still an analysis of the facial validity of regulations 47.07(1)(a) and (d). (Appendix B, p. 8)

The State's highest court defined the proof necessary to show a regulation arbitrary and capricious as follows:

> Rather, a plaintiff challenging a regulation as arbitrary and capricious bears the burden of 'proving *on the record' the absence of any conceivable ground* upon which the rule may be upheld. . . . . (citations omitted). (emphasis supplied) (Appendix B, p. 10)

In addition, the Supreme Judicial Court of Massachusetts, in making its substantive due process analysis, i.e., in addressing the problem of whether or not the regulation was arbitrary, capricious or unreasonable, made the same presumptions in favor of its validity that it would apply to its determinations of the validity of a statute. As the Court said "thus we must apply all rational assumptions in favor of the validity of the administrative action . . .". (Appendix B, p. 9)

The Supreme Judicial Court further reversed the trial judge's finding that it was unconstitutional for the regulation to be permitted to ban the prior approved insurance policies already being sold in Massachusetts without the regulation requiring a hearing either before or after the banning of the policies, notwithstanding the fact that the trial judge found that a property interest attached to the previously approved insurance policies. The Supreme Judicial Court distinguished between the contents of the approved policies and the right to future sales to find that a hearing was not necessary constitutionally to ban future sales of previously approved policies.

The court said as follows:

> The plaintiffs interest is in future sales to new purchasers of previously approved policies. This is not a property interest, the deprivation of which requires a hearing to satisfy due process. (citation omitted) (Appendix B, p. 14)

Reasons for Granting Writ

I. The Decision of the Highest Court of Massachusetts Presents a Novel Question Under the Due Process Clause of the Constitution, When It Denies to the Petitioner the Right to Effectively Challenge the Constitutionality of a State Regulation in Its Judicial System.

The Supreme Court of the United States has long established that a state may not deny the right of a litigant, with

proper standing, to attack the constitutionality of a regulation. It must permit the litigant to contest both the surface validity of the regulation and the validity of the regulation in practice. Failure to permit such a review by statute (or court decision) deny the petitioners due process of law under the Fourteenth Amendment of the United States Constitution and the equal protection of the laws.

> We may assume for present purposes that no pronouncement of a legislature can forestall an attack upon the constitutionality of the prohibition. A statute would deny due process which precluded the disproof in judicial proceedings of *all facts* which would show or tend to show that a statute depriving a person of a suit, liberty or property, had a rational basis.

United States v. Carolene Products Company, 304 U.S. 144, 152 (1938).

Furthermore this Court has stated that where the existence of a rational basis for legislation, whose constitutionality is attacked, depends upon facts beyond the sphere of judicial notice, such facts must properly be made subject to judicial inquiry. *Borden Farm Co. v. Baldwin*, 293 U.S. 194 (1934). In addition the constitutionality of a statute (or regulation) predicated upon the existence of a particular state of fact, may be challenged by showing to the Court that these facts have ceased to exist. *Charstleton Corp. v. Sinclair*, 264 U.S. 543 (1924).

As stated by Justice Brandeis:

> Unless the evidence and the special facts relied upon by the district court are of such a special nature that they could not conceivably establish that the action of the state was arbitrary and unreasonable, the state supreme court obviously erred in refusing to consider these special facts.

Nashville and St. L. Ry. Co. v. Walters, 294 U.S. 405, 410 (1935).

It is the contention of the petitioner that the decision of the highest court of the Commonwealth of Massachusetts has denied to the petitioner its right to effectively contest the validity of the regulation constitutionally; in practice, on its face. This result is arrived at in summary by the following actions of the Supreme Judicial Court of Massachusetts:

> (1) Failing to consider the special facts found by the trial court at a trial which was held two years after the adoption of the contested regulation. These facts dealt with changing circumstances, the practical impossibility of writing insurance policies to satisfy the regulation, the actions of the Division of Insurance in enforcing the regulation, and the impact of the regulation upon an insurance policy of Blue Cross/Blue Shield from which the terms of the regulation were derived.
>
> (2) Assuming that evidence which proved that a regulation was "arbitrary, capricious or unreasonable" attacks only the facial validity of the regulation and does not support a finding of "arbitrary, capricious and unreasonable" in practice.
>
> (3) By denying to the petitioners the "rational basis test" to prove a regulation is arbitrary, capricious and unreasonable and instead imposing on the petitioner to prove "no conceivable basis" for the regulation's validity.
>
> (4) By applying to a due process analysis, the presumption in favor of the regulation similar to a presumption in favor or a statute.
>
> (5) Allowing the regulation to ban the future sale of previously approved insurance policies of the petitioner without requiring either a 'pre' or 'post' hearing.
>
> (6) Denying to the challenger of a regulation the same evidence permitted to the 'state' in defense of its regulation.

The result of the rules applied by the Supreme Court of Massachusetts is to make the regulation unreviewable, a denial of due process under the federal constitution.

II. THE SUPREME JUDICIAL COURT OF MASSACHUSETTS ERRED IN HOLDING THE TRIAL COURT'S DECISION FAILED TO FIND FACTS SUFFICIENT TO INVALIDATE THE CONTESTED REGULATION UNDER THE DUE PROCESS CLAUSE OF THE FEDERAL CONSTITUTION.

A. *The Trial Court complied with standards of review of a regulation under the due process clause of the Federal Constitution.*

American Family in its "Substitute Petition For Declaratory Relief" brought petitions to test the "surface validity" of the contested regulations and to test the validity of the regulations based on "particular facts." *Massachusetts State Pharmaceutical Association v. Rate Setting Commission*, 387 Mass. 122, 126 (1982). Differing from the plaintiffs in *Grocery Manufacturers of America, Inc. v. Department of Public Health*, 379 Mass. 70, 77 (1979), and in *Purity Supreme v. Attorney General*, Mass. Adv. Sh. (1980) 1349, the plaintiffs, here, did in fact try before the Superior Court the particular facts upon which it based their allegations that the contested regulations were illegal.

Differing from the Justice whose case was appealed to the Supreme Judicial Court in *Massachusetts State Pharmaceutical Association, supra*, the Justice of the Superior Court in this case, rendered a decision deciding *all* of the issues that were properly raised. These included a decision of law concerning the surface validity of the contested regulations, and decisions based on findings of facts from evidence presented at the seven (7) day trial. He also decided the procedural and constitutional issues presented to him. *Compare Massachusetts Pharmaceutical Association v. Rate Setting Commission, supra* at 387 Mass. 127. The trial court carefully applied the burden of proof. The trial court based its decision, as to the validity in practice of the contested regulations, solely on

evidence at the trial. *Ibid.* The court's analysis of surface validity was based on accepted standards of statutory construction and legislative history as set forth in the decision.

B. *The Supreme Judicial Court erred in ignoring the "special facts" found by the Justice of the trial court.*

Notwithstanding the fact, that the Massachusetts Supreme Judicial Court had declared that it would not reverse findings of fact of a trial court in proceedings pursuant to G.L. c. 231A (a declaratory judgment act), unless the court found such findings to be "plainly erroneous" or as also expressed "plainly wrong". *Zuckerman v. Blakely*, 3 Mass. App. Ct. 685, 687 (1975); in this case the court ignored its previously enunciated rule by simply announcing that the facts found by the lower court did not address the problem raised, *i.e.*: that the facts found addressed the surface validity of the regulation rather than the validity of the regulation in practice. Although admitting, that all of the findings of the trial court were based on the evidence submitted (and in fact the evidence was uncontradicted), the Supreme Judicial Court of Massachusetts chose to ignore the special findings of facts by simply characterizing them as going to a different issue. That the Trial Judge, understood the difference, between the surface validity and validity of the regulation in effect is clear from his decision. Each section of it deals with evidence that was introduced by witnesses.

In summary, what was proven and found by the trial court was the impracticability of writing an insurance policy under the existing regulation, *i.e.* that in fact the regulation had unconstitutionally banned health insurance which simply named a disease as the insured against risk. The petitioner also contested the validity of such an assumption, even as a matter of surface validity. But clearly the evidence at trial reveals that

banning such policies by the regulation was unconstitutional in practice. The judge found this to be the fact by finding the regulation to be arbitrary, capricious and unreasonable, the constitutional standard for invalidation under the due process clause.

The United States Supreme Court requires consideration by the State reviewing court of such "special facts", notwithstanding the result which may be obtained by the reviewing court after such a review. *Nashville & St. L. Ry. Co. v. Walters*, 294 U.S. 410 (1935).

The circumstances in the *Nashville Case, supra*, are identical to those raised in the case from which we appeal. The plaintiff had attacked the regulation as "arbitrary and unreasonable" so as to deprive it of property without due process of law in violation of the Fourteenth Amendment.

> "The trial court found that, with one exception (no exception here) the evidence fully supported every allegation of fact in the bill. It held that the order and the statute as applied, in so far as they require the railway to pay one half the cost of the underpass are arbitrary and unreasonable and that they are void. 294 U.S. at 414.
>
> Upon appeal, the Supreme Court of the state reversed that decree; order the bill dismissed; and allowed an appeal to this Court.
>
> The Supreme Court declined to consider the special facts relied upon as showing that the order and the statute as applied were arbitrary and unreasonable; it did not pass upon the question whether the evidence sustained those findings. It held that the statute was upon its face constitutional; that when it passed the state had, in the exercise of its police power, authority to impose upon railroads one half of the cost of eliminating, existing or future grade crossings; and that the court could not "any more consider" whether the provisions of the act in question have been rendered burdensome or unreasonable by changed economic and transportation conditions . . ." *Ibid.*

The rule to be applied in determining whether or not a statute (or regulation) is valid in practice has been enunciated by the United States Supreme Court to be the same, whether or not the regulation is being attacked as to its surface validity, or the validity of the regulation in practice.

> "A rule to the contrary is settled by the decisions of this Court. A statute valid as to one set of facts may be invalid as to another. A statute valid when enacted may become invalid by change in the conditions to which it is applied. *The police power is subject to the constitutional limitation that it may not be exerted arbitrarily or unreasonably.*" (emphasis supplied) *Nashville, supra* at 415.

294 U.S. at 415.

Therefore the Supreme Court of Massachusetts erred in determining that it did not have to consider the 'special facts' found by the trial justice simply because those facts dealt with the question as to whether or not a regulation was unreasonable, arbitrary or capricious. The standard of "unreasonable, arbitrary or capricious", the only reason given by the Supreme Judicial Court, for not reviewing the "special facts" found by the trial court, is not a basis for deciding that the justice of the trial court only dealt with the surface validity of the regulation.

III. The Application of the Contested Regulation to the American Family Life Assurance Company Unconstitutionally Deprived it of a Substantial Property Interest in Its Insurance Policies Without Due Process of Law.

The plaintiff has two specified disease insurance policies which were approved for issuance and sale before the effective date of regulation 211 CMR 47.00. American Family Life Policy Number A-6021, submitted and approved by the Division in a letter dated April 25, 1974. A second specified

disease policy of American Family Life, A-8011, was submitted and deemed approved in a letter from the division dated January 6, 1977. Both of these insurance policies were approved for issuance and sale pursant to the Commissioner's statutory authority in G.L. c. 175, § 108.

While there is a procedural distinction in section 108 as to policies which are formally approved by the Division and those which are "deemed approved" by the Division, the effect of such approval is the same. Pursuant to both approval procedures, both policies may properly and lawfully be issued and sold in Massachusetts.

Moreover, after the promulgation of regulation 211 CMR 42.00 in 1974 by Commissioner Ryan, those approved and issued before December 1, 1974 were still in effect. Such policy forms were not affected by 211 CMR 42.00. They were protected by a ruling of the Commissioner and Chief Counsel of the Division, and by the language of the regulation which "grandfathered" previously-approved insurance policies. Therefore, policy forms which had been approved prior to the adoption of 211 CMR 42.00 could be issued for renewal and for new business, whether or not they conformed to 211 CMR 42.00. This ruling was applicable to plaintiff's policy number A-6021.

In addition, American Family Life Insurance Policy A-8011 deemed approved on January 6, 1977 was approved for issuance and sale by the Division pursuant to G.L. c. 175, § 108, despite its noncompliance with 211 CMR 42.00. It could be, and was, lawfully sold in Massachusetts prior to the adoption of 211 CMR 47.00.

Therfore, in accordance with the Commissioner's statutory approval authority and the practice of the Division of Insurance the plaintiff lawfully issued and sold both policies A-6021 and A-8011. In addition, section 108, subdivision 4, provides that any policy sold or delivered will be interpreted as between the policyholder and the insurance company to be in compliance with minimum standards set out in section 108.

However, when 211 CMR 47.00 was promulgated in September of 1979, it was applied retroactively to all policies previously-applied. The new regulation did not have the same prospective effect as was given to 211 CMR 42.00. No previously-applied policy was "grandfathered" by the new regulation. While the Commissioner has not formally withdrawn his approval of American Family Life policy numbers A-6021 and A-8011, he has taken the position that such policies may not be issued or sold, and that those companies selling such policies not in compliance with the standards of 211 CMR 47.00 will be prosecuted. By his actions and by his application of 211 CMR 47.07(1), the Commissioner has banned the sale of A-6021 and A-8011

The effect of the adoption of 211 CMR 47.00 and its application to plaintiff is to prohibit the issuance and sale of these two previously-approved policies of American Family. Such application of 211 CMR 47.00 deprives American Family of the ability to do business within the Commonwealth of Massachusetts with respect to the issuance and sale of two already-approved specified disease insurance policies. Such absolute prohibition of the issuance and sale of such policies for which American Family was authorized to sell this Commonwealth, without an adjudicatory hearing under section 108, is a deprivation of American Family Life's substantial property interest without due process of law in violation of the United States Constitution, Fourteenth Amendment, and the Massachusetts Constitution, Declaration of Rights, Art. 1, 10 and 12.

Moreover, substantial due process safeguards protect the plaintiff's interest in doing business in the Commonwealth. *Aetna Casualty & Surety Co. v. Commissioner of Insurance*, 358 Mass. 272 (1970). In *Aetna* the Court stated: "The writing of insurance is a lawful business and the Commonwealth may not impose unconstitutional conditions upon the exercise of the right to engage therein." 358 Mass. at 281 and cases cited.

There may be nondiscriminatory "regulation of unlawful private occupations where there is a reasonable relation between the type of regulation undertaken and significant aspects of the public interest." *Milligan v. Board of Registration in Pharmacy*, 348 Mass. 491, 497 (1965).

> "When regulation is attempted beyond such [health and safety] matters, more difficult questions of constitutional validity may arise concerning whether particular statutes, regulations, or policies or their application in particular circumstances, bear a reasonable relation to significant aspects of the public interest."

348 Mass. at 498. Particularly in this Commonwealth, decisions:

> "indicate that there will be careful judicial scrutiny of administrative regulatory activity tending to prevent qualified persons from engaging in an ordinary occupation to determine whether such regulatory activity has in fact any reasonable constitutional justification for the protection of the public rather than some merely private objective . . ."

Ibid.

According to *Milligan*, these substantial property interests of American Family entitled the plaintiff to an adjudicatory hearing prior to any application of the challenged regulation to its previously-approved policies.

In *Milligan* the Supreme Judicial Court held that procedural due process of law required that the applicants for permits to conduct a drug store be given the opportunity for an adjudicatory hearing before being denied such permits, and thus being precluded from the pursuit of a lawful vocation. 348 Mass. at 499. The decision rests upon the denial of the applicant's constitutional right to pursue an occupation without the opportunity for a hearing.

The observation that an agency can act legislatively but not judicially without a hearing is unsatisfactory in various

respects. "The true principle is that a party who has a sufficient interest ... at stake in a determination of governmental action should be entitled to an opportunity to know and to meet ... unfavorable evidence in adjudicative facts. ..." *Milligan, supra*, at 496, *quoting*, Davis, *Administrative Law Treatise* (1958 et seq., 7.02, page 415). It is apparent that the plaintiff in the present case has a significant interest at stake. The use of statutory authority under section 110E as a basis of prohibiting the issuance and sale of a particular form of insurance, already authorized, is a gross deprivation of rights without due process of law and *clearly* violated American Family Life's constitutional rights.

Certainly the right in an approved insurance policy is a constitutionally protected "property interest" of the petitioner within the meaning of the Fourteenth Amendment. *Arnett v. Kennedy*, 416 U.S. 134 (1976). In *Arnett, supra* a plurality of the U.S. Supreme Court required at least a "post determination" hearing for procedural due process, *i.e.*, a hearing after the fact, if one was not provided in advance.

The majority of the court in addressing the origin of the right to a hearing determined that the constitution of the United States determines what process is due.

> The plurality opinion evidently reasons that the nature of appelle's interest and continued federal employment is necessarily defined and limited by the statutory procedure for discharge that the constitution will guarantee a procedural due process or cause to appellee no procedural protection against arbitrary or erroneous discharge other than those expressly provided in the statute. The plurality will thus conclude that the statute governing federal employee's property interest, but also the extent of the procedural protection to which he may lay claim ... *this view misconceives the origin of the right to procedural due process. That right is conferred, not by legislative grant, but by constitutional guaranty.*

416 U.S. at 166-167 (emphasis supplied)

By the reasoning of the majority of the Supreme Court of the United States therefore, the right of American Family Insurance Company to further market an insurance policy form, which was previously approved properly under all the laws of the state, could not be extinguished by a regulation which denied to American Family a hearing. Approval of the policy form gave to American Family Assurance Company the right to sell the insurance described on that policy form in the state. Such is the constitutional property interest, because the right to the words and the description of the policy, without the right to sell it is meaningless. Therefore, the distinction made by the Massachusetts Supreme Judicial Court, in the contested decision, between the "right to future sales" as opposed to "property interest" protected by the due process clause of the Fourteenth Amendment is error.

IV. The Contested Regulation Is Arbitrary, Capricious and Unreasonable on Its Face and in Practice.

A. *The highest court in Massachusetts applied the wrong standard to determine whether or not a regulation is arbitrary, capricious and unreasonable under the due process clause.*

As set forth above, the determination of the constitutionality of the regulation under the due process clause is a matter of federal constitutional law, and not dependent on the statutes of a State or on the review procedures of the State. (*Arnett, supra* 416 U.S. at 151-154); *Doss v. Lopez*, 419 U.S. 565, 581-584 (1975).

The starting point in a due process analysis must be the appropriate standard of review. *Duke Power Company v. Carolina Environmental Study Group, Inc.*, 438 U.S. 59 (1978). The contested regulation is a social-economic regula-

tion designed to regulate the content of policies to achieve the elimination of provisions which are contrary to the health care needs of the public and the elimination of coverage is so limited in the scope as to be of no substantial economic value. The due process clause imposed is a limitation on the police power of the states in making regulations. A legislature, (or regulator) must not act in an arbitrary, capricious or irrational way. *Usery v. Turner Elkhorn Mining Co.*, 321 U.S. 1, 15 (1976). The regulation must not use so arbitrary and unreasonable as to the deprive (the plaintiff) of property without due process of law in violation of the Fourteenth Amendment. *Nashville, supra*, 249 U.S. at 413. The test to be applied in challenging the constitutionality of economic regulation is the rational relationship test. *Duke Power Company v. Carolina, supra*. The same rational relationship test is applied in an equal protection analysis (*cf. Chicago Board of Health v. Friendship Medical Center, LTD*, 420 U.S. 997 (1975). No case has been found by the petitioner expressing the test of arbitrary, capricious and unreasonable in a due process or equal protection analysis of the Fourteenth Amendment in the manner described by the Supreme Judicial Court of Massachusetts in the case from which this writ is sued. Massachusetts' highest court has stated the test to determine whether or not a regulation is constitutionally arbitrary and capricious as follows:

> A plaintiff challenging a regulation as arbitrary and capricious bears the heavy burden of 'proving on the record' the absence of *any conceivable ground* upon which (the rule) may be upheld. (emphasis supplied) (Appendix B, p. 10)

The Massachusetts Supreme Judicial Court applied the above quoted standard to test the surface validity of the regulation and the validity of the regulation in practice. The trial judge as described above, instead applied the rational basis test.

In addition the petitioner suggests that, in determining whether the state Supreme Court has applied the rational basis test in a proper fashion, the Supreme Court of the United States should also analyze the State Court's interpretation of the legislative goals which underly the regulatory power. The Supreme Court of the United States should consider "the distribution of the states law making authority (as) an important element in the determination of whether the federal rationality test has been properly applied. When the State has given the power of identifying goals exclusively to the state legislature, the Supreme Court should not blindly accept a state court's interpretation of what those goals are. Although considerations of federalism should leave the Supreme Court to give deference to the state court's identification of legislative goals, the Court should not accept a state court's blatant mischaracterization of legislative goals, if it is to insure that the federal test is meaningfully applied." Bice, *Rationality Analysis in Constitutional Law*, 65 Minn. L. Rev. 1, 47 (1980).

B. The Supreme Court of Massachusetts erred in presuming *that a regulation is entitled to the same presumption of validity as a statute.*

The fact that the Supreme Judicial Court of Massachusetts presumed validity of the regulation in the same fashion it would presume the validity of a statute for purposes of due process analysis was clearly enunciated in its decision. In addition the discussion by the Supreme Judicial Court of Massachusetts of its reasons for finding the regulation to be valid clearly indicated that it applied this presumption in a meaningful way so as to reverse the trial court's analysis.

The Supreme Judicial Court stated:

> thus, we must apply all rational presumptions in favor of the validity of the administrative action and not declare it void unless its provisions cannot by any reasonable construction be interpreted in harmony with the legislative mandate.

The U.S. Supreme Court has recently stated:

> We do not view as equivalent the presumption of constitutionality afforded legislation drafted by Congress and the presumption of regularity afforded an agency in fulfilling its statutory mandate.

Motor Vehicle Manufacturing Company of the United States, Inc. v. State Farm Mutual Automobile Insurance Co., 51 U.S.L.W. 4953, 5956 footnote (June 24, 1983).

Petitioner contends that for purposes of a Fourteenth Amendment test of the validity of a state regulation, it is improper to apply the presumption of regularity to the agency which was applied by the Massachusetts Supreme Judicial Court. The discussion of the Supreme Judicial Court of Massachustts in its decision indicates that it applied this presumption in rejecting the trial court's findings that the regulation was arbitrary, capricious and unreasonable. For example, the Supreme Judicial Court attempted to relate the contested regulation to the elimination of sales practices. It is hard to read the regulation and by logic come to a conclusion that it deals with the elimination of improper sales practices, except to the extent that it might ban any policy of insurance which names a disease. The regulation does not permit the elimination of any policy which names a disease, but requires, among other things, that twelve diseases must be named in the policy. It is this fact which the trial court found to be arbitrary, capricious and unreasonable. How can such a requirement of twelve conditions in a policy meant to be written, in any way be related to "unfair sales practices"? This is made even clearer when one remembers that the State Supreme Court also required the challengers of the regulation to meet "the heavy burden of proving on the record the absence of any conceivable ground upon which the rule may be upheld." (Appendix B, p. 10) Again this places an improper burden upon the petitioners who are attacking a regulation under the due process clause of the Fourteenth Amendment.

V. THE PETITIONERS HAVE BEEN DENIED DUE PROCESS AND THE EQUAL PROTECTION OF THE LAW UNDER THE FOURTEENTH AMENDMENT, BECAUSE OF CERTAIN EVIDENTIARY AND/OR PROCEDURAL REQUIREMENTS OF MASSACHUSETTS.

The petitioner as set forth above, was required to prove its case in a trial court by evidence. Challengers of the validity of the regulation were forbidden at the trial of the case in the trial court to introduce in support of their position, any evidence from the record of hearing before the Commissioner of Insurance in adopting the regulation. *Grocery Manufacturers of America, Inc. v. The Department of Public Health*, 379 Mass. 70, 77 (1979), *Purity Supreme v. Attorney General*, Mass. Adv. Sh. (1980) 1349, *Massachusetts State Pharmaceutical Association v. Rate Setting Commission*, 387 Mass. 122, 126 (1982). In finding against the petitioners in this case, the Massachusetts Supreme Judicial Court stated as follows:

> We note that we are, of course, free to consider the evidence before the Commissioner, as well as any other relevant information, including that provided in the briefs, in determining whether there was a rational basis for the Commissioner's regulation (citations omitted). (Appendix B, p. 10 footnote 6)

Yet the petitioner was forbidden by the cases cited above to use the same evidence to attack the surface validity or the validity of the regulation in practice. Therefore, the Massachusetts procedure places the petitioner in an unconstitutionally disadvantageous position in trying a case before a court of Massachusetts, when the state, in defense of the regulation may use evidence not permitted to the petitioners in attempting to defeat its validity. The ruling of the Massachusetts Supreme Judicial Court forbids the petitioners the opportunity to introduce "all facts" to attack the constitutionality of a regulation. Such a ruling is a violation of due process and equal protection clause of the Fourteenth Amendment of the United States Constitution. *Nashville, supra* 415-416. *United States v. Carolene Products Company, supra* 304 U.S. 144, 152 (1938).

Conclusion

For the reasons stated above, petitioner prays a writ of certiorari should be issued to review the judgment of the Supreme Judicial Court of the State of Massachusetts in the above-entitled matter.

Respectfully submitted,

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Appendix A

A1

Commonwealth of Massachusetts
Trial Court

Suffolk SS: Superior Court

AMERICAN FAMILY LIFE ASSURANCE CO., Petitioner	)	
vs.	)	No. 37921
MICHAEL SABBAGH, COMMISSIONER OF INSURANCE, Defendant	)	
UNION FIDELITY INSURANCE CO., Petitioner	)	
vs.	)	No. 40971
COMMISSIONER OF INSURANCE, Defendant	)	

Findings, Conclusions of Law, and Order

The Pleadings

These actions were brought as Petitions for Declaratory Judgments by the petitioners, American Family Life Assurance Company (*American*) and Union Fidelity Life Insurance Company (*Union*), challenging the validity and constitutionality of certain regulations promulgated by the Massachusetts Commissioner of Insurance on September 27, 1979.

The regulations in question govern the issuance and sale of *individual* accident and sickness insurance policies, in contrast to *group* accident and sickness policies. Although ostensibly promulgated under the authority of various statutes

dealing with the regulation of insurance, they were primarily intended to implement the provisions of G.L. c. 175, § 110E.

In its Petition[1] filed on October 24, 1979 as civil action No. 37921, *American* alleges that it had submitted cancer insurance policy forms to the Commissioner in 1974 and again in 1976 which were approved either expressly or by operation of law for sale in the Commonwealth; that sales of such policies were thereafter marketable under the statutes then in effect and under the Commissioner's Regulation 42 [211 CMR 42] which was adopted in the year 1974; that many such policies were sold; that on or about September 17, 1979 the Commissioner issued a new regulation [211 CMR 47.00], the effect of which forbade any further use of said insurance policy forms; that the Commissioner never issued an order to *American* purporting to revoke his earlier approval of said forms; that *American* has never been given a hearing by the Commissioner relative to the possible withdrawal or revocation of his earlier approval; but that the Commissioner did issue an 'Order to Show Cause' to *American* looking to its possible prosecution for the continued use of said insurance policy forms in violation of the terms and provisions of 211 CMR 47.00. Accordingly, the petitioner *American* seeks a declaratory judgment relative to the current status of said forms and its right to market them within the Commonwealth.

More specifically *American* contends that subsection 47.07(1) of Regulation 47, which purportedly authorizes the Commissioner to withdraw his earlier approval of insurance policy forms without first granting a right of hearing to companies adversely affected by such action, are invalid and unenforceable. (¶ 9)

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[1] The complaint before the Court at the time of the trial on the merits was a "Substitute Petition for Declaratory Relief" which, except as to Prayer No. 2, was allowed by the Trial Justice by agreement of the parties. See Transcript Vol. I, pp. 5-67.

American further contends that the provisions of 47.07(1) are invalid as in excess of his regulatory authority under G.L. c. 174, § 110E. (¶ 10)

American further contends that the provisions of 47.07(1) are invalid as not in conformity with the statutory scheme of G.L. c. 175, §§ 108 and 110E. (¶ 11)

American further contends that the mandate of 47.07(1) that any specified disease policy must cover all twelve of the illnesses and accidents listed in said subsection is unreasonable, arbitrary and capricious, and therefore invalid and unenforceable. (¶ 12)

Lastly, *American* contends that 47.07(1) is invalid and unenforceable as in derogation of American's right of due process and equal protection of law under the State and Federal Constitutions. (¶¶ 13 and 14)

In its Prayer for Relief *American* seeks a judgment declaring that Regulation 47.07(1) is in excess of the Commissioner's regulatory powers under the relevant enabling statutes; that it is arbitrary, capricious, and unreasonable; that it is in violation of American's right of due process and equal protection of law; and that it should therefore be declared invalid and unenforceable.

American further prays for a judgment declaring that c. 175, § 110E, insofar as it may allow retroactive withdrawal of a previously approved policy, is unconstitutional as violative of due process.

On October 30, 1979 American's request for a preliminary injunction was denied. (Diamond, J.)

In its Petition filed on March 31, 1980 as civil action No. 40971, *Union* alleges it had received approval for the sale of cancer insurance policies and medicare supplement policies prior to the promulgation of Regulation 47; that the terms and provisions of the Regulation effectively bar any further sale of said policies; and that the Regulation should therefore be declared invalid and unenforceable as in excess of the

powers of the Commissioner under the appropriate enabling statutes. (Count I)

Union further contends that Regulation 47 is invalid and unenforceable for failure of the Commissioner to give notice to *Union* of the public hearing to be held on May 24, 1979 as required by G.L. c. 30A, § 2, and for failure of the notice to advise the public that regulations would be considered which would ban the further sale of cancer disease policies and medicare supplement policies in Massachusetts, or which would permit the revocation of policy forms previously approved. (Counts II, III, VI, and VIII)

Union further contends that Regulation 47 is invalid and unenforceable as purporting to ban the further sale of Union's cancer insurance policies and medicare supplement policies without a prior adjudicatory hearing under G.L. c. 175, § 108(8). (Counts IV and V)

Union further contends that the provisions of Regulation 47 which purport to ban the sale of cancer insurance policies, and which limit the sale of medicare supplement policies, and which ordain policy and rate filing review standards, are invalid and unenforceable as unnecessary to accomplish the purposes of G.L. c. 175, § 110E, subpar's (a) through (e). (Counts VII, IX, and X)

Union further contends that the provisions of Regulation 47 which purport to ban the sale of cancer insurance policies, which limit the sale of medicare supplement policies, and which ordain policy and rate filing and review standards, are invalid and unenforceable as unsupported by substantial evidence, as based upon error of law, as arbitrary and capricious, and as an abuse of discretion. (Counts VII, IX, and X)

Lastly, *Union* contends that those provisions of Regulation 47 of which *Union* complains in its Petition, and the procedures followed by the Commissioner with respect to the hearing on May 24, 1979, were in derogation of Union's rights of due process and equal protection under the State and Federal Constitutions. (Counts III, V, and XI)

In its Prayer for Relief *Union* seeks a judgment declaring that Regulation 47 is invalid and unenforceable for the reasons outlined in its Petition. More specifically, *Union* asks for a declaration that the Commissioner may not withdraw his approval of Union's previously approved individual accident and sickness policies without a prior adjudicatory hearing under G.L. c. 30A.

No question was raised by the parties in this action as to the choice or remedy. All parties agreed that the Commissioner's public hearing held on May 24, 1979 was a rule making proceeding and not an adjudicatory hearing, and that the proper avenue of judicial review is under G.L. c. 30A, § 7, not § 14(7)(e). As outlined in c. 30A, § 7, a Petition for Declaratory Review is a proper remedy. The Petitions of both *American* and *Union* are in good standing. *Consolidated Cigar Corp. v. Dept. of Public Health*, 372 Mass. 844, 364 N.E.2d 1202 (1977); *Mass. Assoc. of Independent Insurance Agents and Brokers v. Comm. of Insurance*, 373 Mass. 290, 367 N.E.2d 796 (1977).

Since the two actions of *American* and *Union* present common issues of fact and law, the Attorney General's motion to consolidate the cases for trial was allowed on June 6, 1980. (Meyer, J.)

The Relevant Statutes

G.L. c. 175, § 108 The basic statute applicable to the delivery or issuance of individual accident and sickness insurance policies, in contrast to those known as group policies, is G.L. c. 175, § 108, which had its origin in St. 1910, c. 493. Subdivision 2(a) of section 108, at all times relevant to these proceedings, reads in part as follows:

> "No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this commonwealth: until a copy of the policy and the table of rates or manual of risks of the company has been on file

> with the commissioner for at least thirty days, unless before the expiration of said thirty days the commissioner shall have approved the policy in writing; nor if the commissioner notifies the company in writing that in his opinion the form of said policy does not comply with the laws of the commonwealth, specifying the reasons for his opinion, provided that such action of the commissioner shall be subject to review by the supreme judicial court; . . ."

Subsection 3(g) of § 108 vests limited regulatory power in the Commissioner as follows:

> "The Commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this section as are necessary, proper or advisable to the administration of this section. This provision shall not abridge any other authority granted the Commissioner by law."

It is noted that the statute makes no provision for regulations affecting the substance or the content of accident and sickness insurance policies.

Subsection A through C of subdivision 8 of section 108 reads as follows:

> "A. The commissioner may, within thirty days after the filing of a copy or form of such a policy, disapprove such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy. If the commissioner shall notify the insurer which has filed any such form that it does not comply with the provisions of this section it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within twenty days after request in writing by the insurer."

"B. The commissioner may at any time after a hearing, of which not less than twenty days written notice shall have been given to the insurer, withdraw his approval of any such form on any of the grounds stated in paragraph A of this subdivision. It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval. The notice of any such hearing shall specify the matters to be considered at such hearing and any decision affirming disapproval or directing withdrawal of approval under this section shall be in writing and shall specify the reasons therefor."

"C. Any person or company aggrieved by any action, order, finding or decision of the commissioner under paragraph B of this subdivision may, within twenty days from the filing of a memorandum thereof in his office, file a petition in the supreme judicial court for the county of Suffolk for a review of such action, order, finding, or decision. The action, order, finding or decision of the commissioner shall remain in full force and effect pending the final decision of the court unless the court or a justice thereof after notice to the commissioner shall by a special order otherwise modify, amend, annul, review or affirm such action, order, finding or decision, shall review all questions in accordance with the standards for review provided in paragraph (8) of section fourteen of chapter thirty A and may make any appropriate order or decree."

In short, the foregoing statutory provisions authorize the delivery and issuance of a health and accident policy if approved by the Commissioner. Where no action is taken within thirty days of the filing of the policy form, the form is deemed to be approved. And once a policy form is approved it cannot be disallowed for further use unless the procedural steps outlined in subdivision 8(A), (B), and (C) are followed.

G.L. c. 175, § 110E In 1973 the legislature enacted Chapter 1081 of the Acts of 1973 authorizing the Commissioner to make rules and regulations with respect to individ-

ual health and accident policies. The body of the Act is found in G.L. c. 175, § 110E, the first paragraph of which reads as follows:

> "The commissioner shall make rules and regulations . . . to establish minimum standards of full and fair disclosure, for the form and content of policies of accident and sickness insurance . . . Such rules and regulations may apply to all, any portion or reasonable classifications of such policies or contracts, and shall be made to bring about:
> (a) reasonable standardization and simplification of coverages to facilitate understanding and comparisons;
> (b) elimination of provisions which may be misleading or unreasonably confusing, in connection either with the purchase of such insurance or with the settlement of claims;
> (c) elimination of deceptive practices in connection with the sale of such insurance;
> (d) elimination of provisions which may be contrary to the health care needs of the public;
> (e) elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders thereof."

The fifth paragraph of section 110E, relative to the promulgation of agency rules and regulations under the authority of 110E, reads as follows:

> "Rules and regulations made pursuant to the authority of this section shall be adopted in accordance with the procedures of section two of chapter thirty A and shall be subject to review as set forth therein."

The statute further provides that the Commissioner may withdraw his approval of any previously certified policy forms not found to be in compliance with regulations issued under section 110E, apparently without providing for an adjudicatory hearing and a right of judicial review. The second paragraph of section 110E reads as follows:

> "When a rule or regulation has been adopted pursuant to this section and an individual policy of accident and sick-

> ness insurance form regulated by section one hundred and eight is not in compliance with such rule or regulation, such noncompliance shall be grounds for a withdrawal of approval of such policy form and the commissioner may withdraw his approval of any such form upon written notice to the insurer specifying his reasons therefor."

Chapter 1081 was approved on November 26, 1973. The Governor's emergency declaration was filed on November 27, 1973.

G.L. c. 175, § 2B The third statute that bears on this case, the 'readability' law, is not directly involved since not contested by the parties, but it has ancillary significance. G.L. c. 175, § 2B, added by St. 1977, c. 801, prescribes minimum printing standards for certain insurance policies, including accident and health policies. The statute reads in part as follows:

> "1. No policy form of insurance shall be delivered or issued for delivery to more than fifty policyholders in the commonwealth until a copy of the policy form has been on file for thirty days with the commissioner, unless before the expiration of said thirty days the commissioner shall have approved the form of the policy in writing as complying with this section; nor shall any such policy be delivered or issued for delivery if the commissioner notifies the company in writing within said thirty days that in his opinion the form of said policy does not comply with the provisions of this section, specifying the reasons for his opinion, provided that such action of the commissioner shall be subject to review by the supreme judicial court . . ."
>
> . . .
>
> "Nothing in this section shall be construed to require the affirmative approval of the commissioner before issuance of a policy form which has been on file for at least thirty days."

Section 10 of Chapter 801 of the Acts of 1977, governing the applicability of the statute, reads as follows:

> "This act applies to all policy forms filed after *July first, nineteen hundred and seventy-eight*. No policy form approved or deemed approved other than under this section shall be delivered or issued for delivery in the commonwealth on or after *July first, nineteen hundred and seventy-nine* unless approved by the commissioner or deemed approved under this section, except a policy delivered to fifty or fewer policyholders in the commonwealth." (Emphasis supplied).

The 1977 Act was approved on December 6, 1977. Originally it was to be effective as to new forms on July 1, 1978 and as to old forms on July 1, 1979. Subsequently this latter deadline as to old forms was eased to provide that the Commissioner could grant a six-month extension to January 1, 1980 to any company demonstrating a good faith inability to have a new form approved by July 1, 1979. St. 1979, c. 222.[2] The new effective date of January 1, 1980 was firm however and after that date no previously approved policy form for any form of health or accident insurance could be used unless it had also received a separate written readability approval.[3]

It is also of interest to note that insurance policy forms are not to be approved under the readability statute unless they are also in conformity with "any other laws." The third paragraph of section 2B reads as follows:

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[2] During the trial there was testimony that in practice the Commissioner granted such extensions freely. Both American Family and Union Fidelity appear to have received extensions for continued use of old forms to December 31, 1979.

[3] Quite apart from the question of whether c. 175, § 2B was to have retroactive effect, all trial counsel proceeded on the assumption that the Commissioner's view that it does have retroactive effect is the correct one. Petitioner counsel have yielded to the Commissioner's interpretation and agree that the policy forms of their clients, American and Union, whether previously approved under sections 108 and 110E or yet to be approved, must be re-cast in readable form so as to pass muster under section 2B.

"3. Where the requirements of this section are met, the commissioner may approve such policy form for use in the commonwealth notwithstanding those provisions of any other laws which specify the content of insurance policies, provided the approved policy assures to the policy-holders and claimants protection no less favorable than they would be entitled to under such other law."

Findings of Fact

The Parties

1. The petitioner, American Family Life Assurance Company of Columbus, Georgia, is a foreign corporation doing business in the Commonwealth and is duly licensed as a foreign insurance company to sell accident and sickness insurance as described in G.L. c. 175, § 47, subdivisions (a) and (d) of the sixth paragraph thereof.

2. The petitioner, Union Fidelity Life Insurance Company of Trevose, Pennsylvania, is a Pennsylvania corporation duly licensed to do business in the Commonwealth and authorized to sell accident and sickness insurance in Massachusetts.

3. The defendant Sabbagh is the Commissioner of Insurance of the Commonwealth of Massachusetts. As such, he is the head of the Division of Insurance in the Department of Banking and Insurance.

4. *Regulation 42* In the fall of 1974 Commissioner Ryan of the Division of Insurance promulgated a regulation entitled 'Rules and Regulations Establishing Minimum Standards of Full and Fair Disclosure for the Form and Content of Accident and Sickness Insurance Sold in the Commonwealth of Massachusetts.' It was designated Regulation 2-74[4] and was later codified as 211 CMR 42.[5]

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[4] Regulation 2-74 was the first regulation promulgated to implement the provisions of the newly enacted G.L. c. 175, § 110E, added by Chapter 1081 of the Acts of 1973 during Commissioner Ryan's term of office. It was also the first regulation governing accident and health policies since the enactment of c. 175, § 108 in 1949.

[5] Joint Exhibit No. 8.

5. The adoption of the regulation followed a notice of public hearing dated March 22, 1974, the distribution of a 15-page packet of the proposed rules and regulations, and a public hearing held on April 24, 1974.

6. Section 1 of Regulation 42 indicated that the document applied to "individual accident and sickness insurance policies."

7. Section 12 of the Regulation made reference to insurance policies which are written to provide coverage for specified illnesses or accidental injuries.[6] The section reads as follows:

> "*Specified Disease or Specified Accident Coverage* Specified disease or specified accident coverage provides coverage which is limited to a delineated or defined field of sickness coverage, such as poliomyelitis, cancer, dental services, or a specifically named or described disease or to a delineated or defined type of accident, such as an automobile accident or trip accident which, in the case of disease, has a maximum limit of no less than $10,000 and which in the case of an accident, provides amounts at least as great as those provided in Section 5."

8. In the year 1975, the Commissioner issued Regulation 3-75[7] amending certain portions of Regulation 2-74 in respects not vital to these proceedings. It became effective upon the date of its filing on August 1, 1975.

9. Section 2 of Regulation 42 stated that it was issued pursuant to the authority vested in the Commissioner by G.L. c. 175, § 110E and c. 175, § 108. Section 3 stated that the Regulation applied to all such insurance policies "issued or issued for delivery in this state on or after the effective date hereof." Sections 4 and 25 stated that the Regulation applied "to all policies of accident and sickness insurance filed with the Commissioner of Insurance on and after December 1,

[6] Sometimes called 'specific disease' policies, or 'dread disease' policies.

[7] Joint Exhibit No. 9.

1974", and further, that the "disclosure requirements" would apply to all such policies "issued on and after November 1, 1974 regardless of when they were authorized for use in this state".

10. In brief, Section 12 of Regulation 42 relating to specific illness coverage took effect as outlined above on November 1 and December 1, 1974 and remained in effect until superseded by 211 CMR 47.

11. Quite apart from whether Regulation 42 expressly or by implication exempted previously approved policies from compliance with its terms, the policy review section of the Division treated them as exempt. It was the view of the Division that they had been 'grandfathered' by Regulation 42.

12. *Regulation 47* On September 27, 1979 Commissioner Sabbagh promulgated a regulation entitled 'Rules and Regulations Governing Individual Accident and Sickness Insurance', later codified as 211 CMR 47.00.[8]

13. At the same time a document was filed with the Secretary of State which amended the previously adopted 211 CMR 42.00 by repealing section 211 CMR 42.05(19) and 2.05(20), by striking out section 211 CMR 42.12, and by inserting in place of 42.12 a new section 42.12 entitled 'Specified Disease or Specified Accident Coverage'.[9] For purposes relevant to this case, such amendments and substitutions replaced the summary description of specified disease and specified accident coverage as it formerly appeared in 42.12 with the new and enlarged definition for specified disease coverage and a new definition of specified accident coverage. The new definition of specified disease insurance is now found in Regulation 47.07(1).

14. The adoption of the regulation came after the following procedural steps: a notice of public hearing to be held on May 23, 1979;[10] a notice of a change in the hearing date to May 24,

[8] Joint Exhibits 10 and 11.
[9] Joint Exhibit 10.
[10] Joint Exhibit 12.

1979 at 10:00 A.M.;[11] a 27-page set of proposed regulations;[12] and a public hearing held on May 24 and 25, 1979 before Deputy Commissioner and Hearings Office, Milton G. McDonald.

15. On September 17, 1979, Deputy Commissioner McDonald filed his 'Opinion, Findings and Decision' with the Commissioner regarding the proposed rules and regulations. Thereafter on September 27, 1979 the Commissioner adopted the 'Opinion and Decision' in promulgating the final regulation 211 CMR 47.00

16. Regulation 47 touches upon many subjects, such as readability standards, medicare supplement insurance, disclosure provisions, standard forms, etc; but insofar as the issues now under litigation are concerned it drastically altered and enlarged the government's involvement in the regulation of individual policies for specified disease coverage.

17. In effect, the 1979 regulation removed the definition of specified disease coverage from the former Regulation 42 by referring the public to the new specified disease regulations embodied in Regulation 47. Section 42.12 of the former regulation, as amended, now reads as follows:

> "42.12. 'Specified disease coverage' provides coverage as defined in 211 CMR 47.07(1)."

18. The new section 47.07(1) reads as follows:

"(1) *Specified Disease Coverage.*

(a) "Specified disease coverage: has a maximum benefit limit of no less than $10,000 and provides benefits for all of the following specifically named or described conditions:

1. Cancer in any of its manifestations.

2. Severe extensive disabling burns and contractures due to burns.

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[11] Joint Exhibit 13.

[12] Joint Exhibit 14.

3. Disabling paralysis of extremities due to inflammation, degeneration, or other benign lesions of the central nervous system.

4. Disabling major bone fractures, bone fusions, joint dislocations, joint fusions, and limb amputations.

5. Acute infraction* of the heart and chronic congestive heart failure.

6. Chronic ulcerative colitis and chronic regional enteritis.

7. Chronic tuberculosis and chronic osteomyelitis.

8. Chronic rheumatoid arthritis, chronic rheumatic fever, chronic chorea, chronic disseminated lupus erythematosus, chronic periarteritis, or other chronic collagen or systematic sensitivity.

9. Addison's disease, pituitary disorders, or other major endocrinopathies, but not including diabetes.

10. Chronic severe or totally disabling pulmonary insufficiency.

11. Chronic hemolytic anemia, chronic aplastic anemia, chronic toxic anemia, and other chronic bleeding disorders requiring continuing therapy, but not including iron deficiency or blood loss anemia.

12. Chronic nephrosis, chronic nephritis, and cystic fibrosis.

The conditions must be verified conclusively by biopsy, X-ray examinations, laboratory determinations or if an external defect, by unequivocal observation.

(b) Internal limits on dollar benefits can be no less than the following:

1. Room and board daily benefits in semi-private accommodations of at least $150 per day or charges, whichever is the lower, for at least 60 days of continuous hospital confinement.

2. All other scheduled benefits must provide a benefit maximum of at least 10% of the total aggregate maximum benefits.

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* (Regulation misprint, infarction???)

(c) Specified Disease Coverage shall be guaranteed renewable, as defined in 211 CMR 47.09(4)(c), to age 65 or to the date a person on Social Security disability, or age 65, is insured under Medicare A and B, and a Massachusetts Medicare Supplement Policy. Specified Disease Coverage may not be sold to anyone over age 65.

(d) Specified Disease Coverage may be sold only as a supplement to Basic Hospital Insurance as defined in 211 CMR 42.07. The benefits shall begin when the coverage in the Basic policy is exhausted.

(e) Any policy covering specified diseases must meet the standards of 211 CMR 47.07(1)(a) through 47.07(1)(d); it may not be sold as Restricted Health Insurance as defined in 211 CMR 42.13."

19. The documents indicate that the new regulation was promulgated under the authority of G.L. c. 175, §§ 2B, 108, and 110E; c. 176, § 26; c. 176A; c. 176B; and c. 176E.

20. By its terms, Regulation 47 was to become effective upon publication (§ 47.03). The date of its publication was September 27, 1979.

21. In the event of conflict between the provisions of Regulation 42 and Regulation 47, the latter was to govern. Subsection 47.02 reads as follows:

"*47.02: Applicability and Scope*

This regulation shall apply to all individual accident and sickness insurance policies and to non-group subscriber contracts of non-profit hospital, medical, and dental service corporation filed with the Division of Insurance, delivered, or issued for delivery after the effective dates of this regulation, except group conversion policies or contracts. Health Maintenance Organizations are exempted from 211 CMR 47.07 and following. No policy or contract covered by this regulation shall be issued or issued for delivery unless it complies with this regulation. This regulation supplements the rules of 211 CMR 40.00 through 42.00; in case of direct conflict between this and earlier regulations, this regulation shall govern."

22. In a literal sense, once section 47.07(1) became law it was no longer possible to market specific disease policies in Massachusetts under Regulation 47 unless the policy provided coverage of at least $10,000, nor unless it covered all 12 categories of disease or illness listed in subsection (a), nor unless it covered actual daily costs up to $150 a day for at least 60 days, nor unless it provided a benefit maximum of at least 10% of the total maximum benefit for all other scheduled benefits, nor unless it was guaranteed as renewable to age 65, nor unless it was sold only to persons under the age of 65, nor unless it was sold only as a supplement to a basic hospital insurance policy. In short, the new specifications were most rigorous and exacting, to the point as will be discussed below that any future sales of specific disease policies were perhaps no longer commercially practicable or possible in Massachusetts.

23. Whether the draftsmen of Regulation 47 intended it to have both prospective and retroactive effect, or prospective effect only, is difficult to resolve from the text itself. Section 47.02 states that "This regulation shall apply to all ... policies ... filed with the Division of Insurance, delivered, or issued for delivery after the effective dates of this regulation ..." This language parallels similar language in sections 4 and 25 of Regulation 42, under which the Commissioner regarded previously approved policies as having been 'grandfathered'. Section 47.02 goes on to say, however, that "No policy or contract covered by this regulation shall be issued, or issued for delivery unless it complies with this regulation" and that "in case of direct conflict between this and earlier regulations, this regulation shall govern." For lack of a clear savings clause in Regulation 47 to salvage previously approved policies, the Commissioner has deemed Regulation 47 to have retroactive effect.

24. *Previously Approved Policies* During the trial of this action the petitioners furnished evidence of specified disease

policies issued by their companies before Regulation 47 took effect which had either been approved by the Commissioner or which had been deemed to be approved.

25. On April 22, 1974, prior to the adoption of either Regulation 42 or 47, *American* submitted a cancer policy[13] to the Division of Insurance for approval under G.L. c. 175, § 108. The form (No. 6021) was approved by the Division for issuance and delivery by letter dated April 25, 1974.[14] Since it antedated both regulations it could lawfully be marketed in the Commonwealth of Massachusetts as approved, subject only to the provisions of c. 175, § 108. The Commissioner could not bar such a sale except by giving notice of his withdrawal of approval and by holding the necessary hearing under subsection 8B of section 108.

26. After the adoption of Regulation 42 in late 1974 but prior to the enactment of Regulation 47, *American* obtained approval for the sale of another cancer insurance policy. On December 1, 1976 the company submitted its policy form A-8011[15] to the Division of Insurance for approval, and by letter dated January 6, 1977 the company was notified that policy form A-8011 was "deemed approved."[16] It was the policy of the department to issue a "deemer" letter upon request in case where the department had not issued its disapproval under section 108, notwithstanding the department's awareness that an approval by default was a matter of law and that a confirmation letter was not required by statute.

27. *American* policies A-6021 and A-8011 were both accident and sickness policies within the meaning of G.L. c. 175, § 47, ¶ 6. In addition, since both policies cover persons for the specified disease of cancer, they are properly classified "specified disease policies" as defined by Section 12 of

[13] Petitioner Exhibit No. 7.
[14] Petitioner Exhibit No. 6.
[15] Petitioner Exhibit No. 8.
[16] Petitioner Exhibit No. 6.

Regulation 42. They will be referred to herein as "specified disease" policies without prejudice to the contention of *American* that they are not subject to the current specified disease provisions of Regulations 42 and 47.

28. At the time it was filed and approved by default, American's policy form A-8011 did not comply with all of the provisions of Regulation 42. It was not noncancellable for life without right to raise the premium rate.[17] It was guaranteed renewable, but it did say that the policy rates could be increased with approval of the Division. Notwithstanding its non-compliance the policy could lawfully be sold in the Commonwealth under c. 175, § 108. The Commissioner could bar such sale only by giving notice of withrawal of approval and by holding the required hearing under § 108.

29. On or about December 10, 1974 *Union* submitted its Cancer Benefit Policy No. DRI-7270 to the Division of Insurance requesting approval. On December 19, 1974 the policy approval section issued a letter of approval.[18]

30. At the same time, *Union* submitted its Cancer Benefit Policy No. 1-2150-20 for approval and on December 16, 1974 the policy approval section issued a letter of approval.[19]

31. On December 27, 1974 *Union* submitted its Cancer Benefit Policy No. DRI-7250-20 for approval, and on January 3, 1975 the Division issued its letter of approval.[20]

32. It was further stipulated by the parties,[21] and the Court so finds, that the specified disease and medicare supplement policies and riders of the Union Fidelity Life Insurance Company listed below were approved by the Commissioner in the year 1977 and 1978.

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[17] *See* 211 CMR 42.05(32).
[18] Petitioner Exhibit No. 14.
[19] Petitioner Exhibit No. 15.
[20] Petitioner Exhibit No. 24.
[21] Joint Exhibit No. 15.

Policy Form Number	*Approval Date*
1-2910-MA	October 14, 1977
1-4940-99	November 10, 1977[22]
1-4950-99	November 10, 1977[23]
1-4930-99	November 10, 1977
DRI-2970-MA	January 25, 1978
1-4310-MA	January 30, 1978
DRI-2960-MA	January 31, 1978
1-4610-MA	March 24, 1978
1-4470-99	April 11, 1978
DRI-8120-MA	June 8, 1978
DRI-8130-MA	July 10, 1978
DRI-8140-MA	June 20, 1978

33. An effort was made during the trial of the action by means of subpoena to have the defendant Commissioner prepare and submit a complete and accurate list of all specified disease policies which had been approved or had been deemed approved by his Department under c. 175, § 108 prior to the date of the trial, but because of the stupendous number of insurance policies of all types on file (literally thousands), and because of the difficulties involved in retrieving them from storage, it was simply not possible for him to do so. He did, however, supply a list of about thirty companies who are licensed to sell health insurance for such illnesses as cancer, heart disease, and leukemia.[24] Whether said companies have in fact marketed dread disease policies in the Commonwealth would depend upon whether they obtained approval of their policy forms prior to July 1, 1978, the date following which all new policies had to be submitted for approval under the readability statute.

34. The defendant attempted to prepare a list of cancer disease policies which had received approval between the dates of January 1, 1973 and December of 1977. This list, as submitted, was as follows:[25]

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[22] Petitioner Exhibit No. 22.
[23] Petitioner Exhibit No. 21.
[24] Petitioner Exhibit No. 1.
[25] Petitioner Exhibit No. 3.

Company	*Form Number*	*Approval Date*
American Family Life Assurance of Columbus	A-6021	5-25-74[26]
American Income Life Insurance Company	CDK (1174)	12-26-74
Union Fidelity Life Insurance Company	DRI-7420	12-26-74[27]
	1-2150-20	12-16-74[28]
	DRI-7270	12-19-74[29]
Mutual Protective Insurance Company	PSA199MP	2-13-75
United Founders Life Insurance	H-20CBR	5-6-75
Massachusetts Indemnity & Life Company	76134	11-29-76
Iowa Fund Life Insurance Company	618,619,620	8-1-77
Executive Fund Life Insurance Company	H-810	(Deemed) 8-7-77
	HR-813	(Deemed) 8-7-77
Bankers United Life Assurance Company	C2-1-877	(Deemed) 10-16-77

35. It is noted that the person who prepared the above list apparently missed the American policy form 8011 mentioned above.

36. The defendant further conceded, and the Court so finds, that the department had approved other policy forms prior to 1973 which had been submitted by American Family Life, Mutual of Omaha, Union Fidelity, and National Home Life.

37. Since the effective date of the readability law on July 1, 1978 no further approvals of specified disease policies have been granted for lack of compliance with either the readability law, or Regulation 47, or both. As for disapprovals, there have been two, each with respect to an effort by the Physi-

[26] Petitioner Exhibit No. 7.
[27] Petitioner Exhibit No. 23.
[28] Petitioner Exhibit No. 15.
[29] Petitioner Exhibit No. 14.

cians Mutual Insurance Co. to add a chemotherapy rider to a previously approved basic hospital insurance policy at no further cost to the policy holder. The two requests for approval, one dated June 24, 1980 and the other dated July 21, 1980, were both rejected by the department for non-compliance with Regulation 47.[30] They failed to comply, among other reasons, for not including all twelve dread diseases listed in 47.07(1).

Further Findings of Fact and Conclusions of Law

38. In their Petitions, and in the presentation of their evidence, both *American* and *Union* contend, either expressly or by implication, that the requirements of Regulation 47.07(1)(a) that specified disease policies *must insure against all twelve of the diseases* listed in the subsection, no more and no less, should be declared invalid as an arbitrary, capricious, and unreasonable regulation.[31]

39. Prior to the promulgation of Regulation 42 in 1974 there were no departmental regulations on specified disease insurance polices. They were governed solely by the terms of G.L. c. 175. After 1974 Regulation 42 § 12 defined specified disease policies as those which are "limited to a delineated or defined field of sickness coverage, such as poliomyetlitis, cancer, dental services, or a specifically named or described disease" etc. It then indicated that such policies must have "a maximum limit of no less than $10,000" and that accident policies must provide benefits at least equal to those set forth in section 5 of the Regulation. In addition, 'specified disease' policies were required to comply with the thirty-seven criteria as applicable of section 5, the definition requirements as applicable of section 6, the disclosure requirements of section 14, and the format requirements of sections 20 and 21. While Regulation 42 was in force, *American* and *Union*

[30] Petitioner Exhibits Nos. 4 and 5.

[31] American Petition ¶ 12; Union Petition Count VII.

issued some of the specified disease policies which were subsequently threatened when Regulation 47 took effect.

40. Following the adoption of Regulation 47 in the year 1979 specified disease policies could no longer be issued on a single disease basis. Henceforth they would have to include all twelve diseases listed in subsection 47.07(1)(a).[32] In ruling that a specified disease policy must include all twelve diseases or none at all, the Commissioner presumably relied upon subsections (d) and (e) of the first paragraph of § 110E as the source of his authority for there appear to be no other provisions in either § 108 or § 110E to which resort could be had for such power. Prescinding for the moment from the petitioner's argument that his authority to make rules and regulations under (d) and (e) are subordinate to the overriding limitation in the first paragraph of section 110E to the effect that regulations may only be issued to establish "minimum standards of full and fair disclosure," and assuming 'arguendo' that (d) and (e) do allow him to rule on matters of substance and content as well as on matters of disclosure, then it would follow that a literal reading of the statute gives the Commissioner untrammeled discretion to outlaw, by regulation, any policies which in his judgment are "contrary to the health care needs of the public" or of "no substantial economic value," subject only to the constitutional caution that they not be arbitrary, capricious, or unreasonable as a matter of law. We turn therefore to an examination of Regulation 47.07(1) under these two standards and in the light of the evidence introduced at the trial.

41. The evidence addressed the propriety of the Commissioner's twelve-disease classification from an economic, actuarial, and health care standpoint. Precisely which insurance policies have substantial economic value and which

[32] During the trial of the action the parties agreed that the Department has so interpreted and applied the regulation and that such an interpretation logically follows from a literal reading of § 47.07(1), (a) through (e).

do not may vary according to the eye of the beholder. The issue is not one of mathematical precision. Economic value to a particular consumer may take many twists and turns. One man's economic poison may be another man's economic broth. The following are some of the factors applicable to a determination of the economic value of insurance: (i) the relationship between benefits available and premiums paid; (ii) the frequency of occurrence of the peril insured against, sometimes called the 'odds'; (iii) the significance or the size of the premium, i.e., whether substantial or nominal; (iv) whether the policy fills a particular need of the insured, i.e., whether it fills a void in the holder's insurance requirements; (v) the benefits of improved attitude and personal efficiency which can follow from peace of mind and freedom from worry; and (vi) an insurable interest in the holder, i.e., a genuine incidence of personal risk in contrast to a mere wagering contract.

42. The population is presently subject to a high incidence of heart disease and cancer, both of which can result in extended periods of disability and great expense for medical care and treatment. Insurance policies written to afford protection against such eventualities would therefore be consistent with the "health care needs of the public" and would have a "substantial economic value" to a major portion of the population, assuming a proper ratio of benefit to premium and a proper ratio of premium to risk.

43. Conversely there is a dearth of actuarial data in the insurance industry on the incidence and average expense of many of the other diseases listed in the Commissioner's mandatory twelve-disease classification. A sound analysis of the relationships between benefit and premium and between premium and risk is not possible. One thing is certain however; the premium cost of a twelve-disease policy, whether based upon mere speculation or whether based upon whatever actuarial and medical data might be available,

would be much higher than a single-disease policy covering heart or cancer alone. It is therefore not possible to say with any degree of certainty that a specified disease policy covering all twelve of the Commissioner's categories would have a substantial economic value to the holder vis-a-vis the particular premium charged, whatever the premium range might be.

44. For the same reasons one could not say with reasonable certainty that a policy covering all twelve diseases would have substantial economic value but then one covering only eleven would not. There would be no factual basis to conclude, for example, that a policy excluding category No. 6 dealing with ulcerative colitis and chronic regional enteritis, but which does include the remaining eleven, would have no economic value, particularly in view of the lack of statistical and actuarial data on the incidence and expense of the diseases excluded or of the other eleven which are covered. Conversely, one cannot reasonably conclude that a policy covering all twelve categories would have substantial economic value but that the addition of a thirteenth or fourteenth would render the policy otherwise.

45. The Commissioner's mandatory twelve-disease classification has produced such a bizarre result that an attempt by one company (the Physicians Mutual) to add a chemotherapy 'rider' to previously approved cancer treatment policies at no further cost to the customer met with disapproval since it was a specified disease item not applicable to the full range of illnesses listed in the twelve item schedule. It would have made no difference whether the chemotherapy rider was to be added to a single-disease policy, such as cancer, or to be a basic hospital policy. It would still fail of approval even though chemotherapy treatment would hardly be pertinent to many of the twelve categories of illnesses, such as burns, fractures, arthritis, etc.[33] In its correspondence, the Physi-

[33] Petitioner Exhs. 4 and 5; Tr. III 4-32; Tr. III 109-111; The Witness: "If it was open to any disease, then it would be acceptable. But in narrowing it down, it becomes a specific disease form", Tr. III: p. 111.

cians Mutual Company attempted to explain that the purpose of the 'rider' was merely to show that chemotherapy would be included with the X-ray, radium, and cobalt therapy provision of the policy, that the company was currently paying such benefits, but that it wanted to make sure the beneficiaries of the policy fully understood their rights. Nonetheless the Division declined to approve the 'rider'.

46. In short, there appears to be no rational basis for the twelve-disease classification from an economic value or health care standpoint.

47. Evidence was introduced during the trial attacking the propriety of the Commissioner's twelve-disease classification from a medical point of view, suggesting an absence of any reasonable basis to nominate all twelve diseases for incorporation in a single health insurance policy. To begin with, the classification is not one of disease but of categories of diseases. Within any one category there can be many separate diseases. For example, chronic nephrosis (listed in category No. 12) can comprise over 1000 different kinds of diseases, such as chronic interstitial nephritis, chronic pneumerial nephritis, chronic infectious nephritis, etc. Cancer and heart illnesses involve a myriad of different diseases. Not only is lung cancer a particular type of cancer, there are many different types of lung cancer, some more lethal than others. It would be fair to say that the twelve-disease classification embraces as many as 3000 diseases which are recognized by the medical profession as distinct from one another.

48. Further difficulties arise where one must draw a fine line in deciding whether a particular disease falls within one of the Commissioner's twelve categories because of the vague and rather general manner in which the list is drawn. Terms such as 'disabling', 'acute', 'chronic', and 'systematic sensitivity' are not always capable of exact application, even when applied to a particular disease, to say nothing of an attempt to apply them to a broad category of diseases. Other

definition problems arise when attempting to classify diseases with a broad brush, as for example in category No. 11 which lists "chromic hemolytic anemia" but excludes "iron deficiency or blood loss anemia," since chromis hemolytic anemia can in fact involve an iron deficiency.

49. Other than to conclude that all twelve categories might involve catastrophic results to the patient, although not necessarily so, there appears to be no common medical thread or linkage to justify lumping the twelve together in a single medical grouping or medical insurance policy. If the Commissioner's motivation was to incorporate all catastrophic illnesses under one umbrella so as to provide blanket insurance coverage, his grouping does not do the job. Obvious omissions, for example, would be the disease of diabetes which can involve several catastrophic manifestations, such as diabetic coma, low-blood sugar from too much insulin, etc.; disease of the brain, such as a ruptured aneurism causing paralysis, coma, or other complications' diseases of the lungs, such as pulmonary infarcation and other chronic lung diseases aside from tuberculosis; and diseases of the heart which are not on the list, such as chronic pericarditis, rheumatic heart disease, and various congenital valvular diseases.

50. Nor in fact can all twelve on the list be properly characterized as diseases, as for example category No. 4 relating to bone fractures, joint dislocations, amputations, etc. Bone fractures generally result from trauma and are not disease related. Amputations can result from either trauma or disease.

51. In short, from the standpoint of the catastrophic illness test, there appears to be no rational basis for the Commissioner's twelve-group classification.

52. If the Commissioner's motivation was to list all categories of diseases where the incidence of occurrence is high, the list falls short of the mark. The likelihood of occurrence among the twelve categories is extremely variable. Although

the frequencies of cancer and heart disease (categories Nos. 1 and 5) are well recognized, there is a very low incidence of an illness such as Addison's Disease (No. 9). Although rheumatoid arthritis is commonly encountered, such ailments as tuberculosis and chronic aplastic anemia are much less common. And within any one category, the frequency of occurrence varies widely. The rates of occurrence of various types of cancer and heart disease, for example, are in no sense the same. Lung cancer has a different rate of occurrence than liver cancer. Cancer among the aged has a different statistic than among the young. Cancer and lung afflictions in some types of employment vary from other types of employment. The same variables would be true in virtually all of the diseases that fall within the Commissioner's twelve categories.

53. In short, from the standpoint of frequency of occurrence there appears to be no rational basis for the Commissioner's twelve-group classification.

54. If the Commissioner's motivation was to list twelve categories of diseases where the cost of treatment is high or catastrophic, the list disappoints. The treatment cost of totally disabling pulmonary insufficiency, for example, is fantastically high, whereas the cost of skin cancer treatment can be relatively inexpensive. The cost of treating chronic nephritis or cystic fibrosis can be enormously high, whereas the costs associated with a fast-acting terminal cancer may be low. Bone fractures may involve minimum expense even though disabling, whereas bone fusions may involve major expense. Nor does the Commissioner's list include some of the more commonly encountered high-cost diseases, such as coronary heart disease and by-pass surgery, coronary, insufficiency, diabetes, etc.

55. In short, from the standpoint of medical cost there appears to be no rational basis for the twelve-group classification.

56. If the Commissioner's motivation was to fashion a list of twelve categories of diseases that are of comparable severity, the list fails to do so. Some of the diseases that fall under the twelve categories are life-threatening or completely disabling, but many are not. In the case of ulcerative colitis, for example, some cases are fatal and some are mild; yet in all instances they would properly be called chronic. An acute infarction of the heart can have either a severe or a mild result. Burn injuries cover a wide spectrum of result. Some burn "contractions" are disabling and some are not. And which burn injuries are to be recognized as "severe, extensive, disabling burns" under category No. 2, and which are not, may be difficult to assess. Attempts to so classify them may produce varying opinions.

57. Further, from the standpoint of severity the twelve-item list fails to include many of the more common. For example, diseases of the eye, diseases of the skin such as a chronic panthocis which can be crippling or fatal, as well as other infectious diseases of a chronic or semichronic nature, are not on the list.

58. In short, from the standpoint of medical severity there appears to be no rational basis for the twelve-group classification.

59. It was shown that the twelve-disease listing in Regulation 47.07(1)(a) was lifted, word-for-word, from a 'Prolonged Illness Certificate' of the Blue Cross-Blue Shield organization dated February 1, 1968 (Rev.), the defendant implying that if it had been tried and tested since 1954 when the predecessor 'PIC' document was first used by Blue Cross-Blue Shield, it must be a workable document and therefore suitable for incorporation by the Commissioner in his own regulations.

60. As embodied in Regulation 47, however, the twelve-disease listing has an impact far different than it had in the Blue Cross-Blue Shield insurance policy structure. In Regulation 47 it applies to all individual health and accident policies,

which in turn must satisfy all of the other stringent requirements of the Regulation. As used by Blue Cross-Blue Shield it had a much more limited effect.

61. With respect to Blue Cross-Blue Shield *group health and accident policies, the coverage afforded by the twelve-disease list falls within the broad scope of the Blue Cross-Blue Shield Master Medical policy. And since group* policies involve an entirely different actuarial basis and pricing mechanism they cannot be used as reference points in evaluating insurability questions relating to *individual* health and accident policies. The two are simply not comparable.

62. In 1956 the Blue Cross-Blue Shield organization broadened the scope of its basic *individual* health and accident policies by combining both its basic and supplemental benefits in a single policy known as its Major Medical policy. Hence its broad *group* policy was known as its Master Medical and its broad *individual* policy was known as its Major Medical.

63. In 1961 Blue Cross-Blue Shield offered individual customers a limited basic policy[34] supplemented by its Prolonged Illness Certificate as an alternative to its higher cost Major Medical package. This was the very same 'PIC' form which has been referred to in this case as the source of the Commissioner's twelve-disease listing in 47.07(1)(a).

64. As employed by Blue Cross-Blue Shield the 'PIC' supplement to an individual basic policy enlarged an individual's coverage to include the twelve-disease listing but only to the extent of the limits set by Blue Cross-Blue Shield, viz: $12 a day but not in excess of a maximum payout of $5,000. In contrast to a Blue Cross-Blue Shield individual Major Medical policy which usually afforded coverage up to 80% of all actual cost, the alternative of a Blue Cross-Blue Shield basic individual policy plus the PIC supplement was much less expensive to the holder.

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[34] A thirty, sixty, or ninety-dollar fixed rate indemnity policy.

65. Following the promulgation of Regulation 47 in 1979 any further sales by Blue Cross-Blue Shield of its Basic individual policy plus its 'Pic' would have had to meet all requirements of Regulation 47, notably the $150 per day minimum and the over-all $10,000 minimum set forth in 47.07 (1)(a) and (1)(b). For all practical purposes this demolished the actuarial basis and pricing structure on which the Blue Cross-Blue Shield had predicated its PIC and made it no longer marketable as before. Faced with the fact that Regulation 47 would push the price of its Basic plus 'PIC' combination up to the level of its Major Medical plan, the Blue Cross-Blue Shield organization withdrew its 'PIC' from the market after 1979. It may now fairly be said that the twelve-disease listing of Blue Cross-Blue Shield which was used the Commissioner as the basis for section 47.07(1)(a) of his regulation is no longer used by Blue Cross-Blue Shield because of the Regulation itself.

66. Blue Cross-Blue Shield does not read Regulation 47 as affecting its 37,090 'PIC' contracts (covering about 70,260 persons) which were sold prior to 1979, but should any of these policies lapse the chain would be severed and Blue Cross-Blue Shield would not feel free to reinstate them. Since reinstatement would be subject to all of the provisions of Regulation 47, a reissuance of these policies would be barred in their present form and context. This apprehension is based upon the Commissioner's announced positions that such is the case.

67. In short, the Commissioner's reliance on the Blue Cross-Blue Shield 'PIC' as a basis for 47.07(1)(a) would appear to have no real validity.

68. Summarizing, the petitioners say that the twelve-disease classification of subsection 47.07(1)(a) cannot be defended as a means to eliminate individual health and accident policies which are "contrary to the health care needs of the public" or of "no substantial ecomomic value to the holders thereof", at least in the sense that those words appear in the

statute. The classification forces a combination of twelve wholly unrelated categories of diseases and conditions which bear no actuarial or medical relation to one another and which differ widely in incidence of occurrence, severity, and cost. Other medical conditions of comparable severity, incidence, and cost to many of those on the list are not included. As applied, the regulation prevents the inclusion of additional coverages even when offered as gratuitous supplements to existing policies. Equally irrational is the insistence that a policy include all twelve of the disease categories on the list and the prohibition of any number less than twelve.

69. In effect, the mandatory twelve-disease requirement effectively prohibits the sale of a single-disease policy even though it may otherwise satisfy the basic intent and purpose of the statute, even though it may meet all remaining requirements of the regulation relative to benefits, costs, and minimum loss ratios, and even though it may in truth have an apparent or proven substantial economic benefit to the consumer.

70. The regulation prevents persons in high risk occupations from insuring against selected risks. It prevents persons who may be particularly susceptible by reason of heredity from obtaining the peace of mind that specified coverage may bring. It dampens any interest on the part of a carrier to experiment, for the benefit of the public, with policies which insure against one ore more of the twelve disease categories of the regulation, although not all, even though predicated upon reasonable and accurate underwriting criteria. And it prohibits companies from offering a more limited protection at loser cost to policy holders who choose to make such a purchase in contrast to the higher cost of a more extensive policy, such as a major medical package, which the purchaser may not want or which he perhaps cannot afford.

71. Lastly, the Commissioner's attempt to force all health and accident insurers who choose to issue specific disease

policies to adopt the twelve-disease listing of the Blue Cross-Blue Shield 'PIC' package, in addition to other restrictive requirements of Regulation 47 which will be discussed below, is destined to have a devastating and perhaps not anticipated result, for as has already been the case with Blue Cross-Blue Shield such restrictions may undermine the economic feasibility of the policies.

72. In evaluating the constitutionality of a legislative act the Court's task is to decide whether the apparent objective of the legislation is rationally related to the promotion of the public safety, health, morals, or general welfare. The State must show that the statute is necessary to promote a compelling governmental interest. A person is entitled to conduct and promote his business affairs free from any arbitrary interference by the government. Undue interference would be violative of due process of law. *Commonwealth v. Henry's Drywall Co. Inc.*, 366 Mass. 539, 320 N.E.2d, 911 (1974); *Opinion of the Justices*, 368 Mass. 857, 333 N.E.2d, 407 (1975); *Mobil Oil Corporation v. Attorney General*, 361 Mass. 401, 280 N.E.2d, 406 (1972).

73. The manner in which a statute seeks to carry out the purpose of the legislative intent must be reasonable. It is seriously in question if found in any sense to be arbitrary, capricious, or unreasonable. The means selected to achieve the statutory purpose must have a real and substantial relationship to the object sought to be attained. *Grocery Manufacturers of America Inc. v. Department of Public Health*, 379 Mass. 70, 393 N.E.2d 881 (1979); *Greenleaf Finance Co. v. Small Loans Regulatory Board*, 377 Mass. 282, 385 N.E.2d 1364 (1979); *Cambridge Electric Light Co. v. Department of Public Utilities*, 363 Mass. 474, 295 N.E.2d 876 (1973); *Commonwealth v. Diaz*, 326 Mass. 525, 95 N.E.2d 666 (1950).

74. Although terms such as unreasonable, arbitrary, and capricious are generic rather than specific, and for that reason may seem to be unworkable as standards for judicial

review, this is not the case. They have well settled common law meanings and have been a part of our jurisprudence for a long period of time. When employed as standards of judicial review, their meaning and application can be elicited and safely resolved on the facts of the particular case. *Commonwealth v. Gustafson*, 370 Mass. N.E.2d 706 (1976).

75. An agency regulation is to be tested on review is much the same manner as a statute. It must bear a reasonable relationship to the purpose of the statute, and it must accomplish its objective in a reasonable and rational way. It may not be drawn in an arbitrary or capricious manner. *Purity Supreme Inc. v. Attorney General*, 80 Mass. Adv. Sh. 1349, 407 N.E.2d 297; *Consolidated Cigar Corp. v. Dept. of Public Health*, 372 Mass. 844, 364 N.E.2d 1202 (1977); *Collella v. State Racing Commissioner*, 360 Mass. 152, 274 N.E.2d 331 (1971).

76. In its review the Court does not concern itself with the wisdom or expediency of a regulation, but only with its validity or constitutionality. In considering the substance of the regulation the Court must resist any tendency to substitute its own judgment on the issues before the agency. The review must proceed on an objective basis only. *Purity Supreme Inc. v. Attorney General, supra.*

77. The approach of the Court to an agency regulation should be as deferential as to an act of the legislature. *Greenleaf Finance Co. v. Small Loans Regulatory Board, supra* All rational presumptions must be accorded in favor of the validity of the regulation. It should not be declared void unless it cannot, by any reasonable construction, be interpreted in harmony with a proper legislative mandate. *Levy v. Board of Registration and Discipline in Medicine*, 79 Mass. Adv. Sh. 1857, 392 N.E.2d 1036 (1979); *Grocery Manufacturers of America v. Dept. of Public Health, supra. Greenleaf Finance Co. v. Small Loans Regulatory Board, supra. Consolidated Cigar Corp. v. Dept. of Public Health, supra. Opinion of the Justices*, 368 Mass. 857. *Cambridge Electric Light Co. v. Dept. of Public Utilities, supra. Collella v. State Racing Commission, supra.*

78. With all of the foregoing in mind, and buttressed by their belief that Regulation 47 reflects a prejudice on the part of the Division against single disease policies 'per se', the petitioners contend that subsection 47.07(1)(a) is arbitrary, capricious, and unreasonable as a matter of law. The Court agrees.

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79. In the presentation of their evidence both *American* and *Union* contend that the Regulation 47.07(1)(d) mandate that a specified disease policy may only be sold as a *supplement* to a basic hospital insurance policy should be declared invalid as an arbitrary, capricious, and unreasonable regulation.

80. Not only must specified disease policies cover all twelve classifications listed in 47.07(1)(a), they can now only be used to supplement basic hospital policies as defined in Regulation 42.07, i.e., policies which provide basic coverage for hospital confinement expenses for a period of not less than 21 days (with a deductible of not more than $100) to the extent outlined in subsections (a), (b), and (c) of Regulation 42.07 which spell out the extent to which a basic policy must defray patient expenses for daily room and board, miscellaneous hospital services, and outpatient services.

81. In addition, the specified disease policies must provide a maximum benefit limit of no less than $10,000 as required by section 47.07(1)(a); they must provide benefits of at least $150 a day or actual cost, whichever is lower, as spelled out in 47.07(1)(b1); they must provide a benefit maximum of at least 10% of the aggregate maximum benefit for all other individual benefits as called for by 47.07(1)(b2); and they must be guaranteed renewable as required by 47.07(1)(c).

82. The insistence of Regulation 47.07(1)(d) that a specified disease policy must be written, if written, to pick up the patient's expenses once the benefits under the basic policy have

been exhausted confronts a would-be insurer of specified disease insurance with perplexing if not insurmountable problems. To fashion a supplementary policy, an insurer would have to be acquainted with every detail of the basic policy to which the specified disease policy will apply. The writer of the supplementary policy would be operating in the dark as to when and under what circumstances its liability would exist, for it would be difficult if not impossible to formulate a benefit and premium plan upon a sound actuarial and economic basis unless all details of the basic policy were known in advance.

83. Given the vast number of basic hospital insurance policies on the market, it is unlikely that an insurer would be interested in selling a supplementary specified disease policy unless as a rider to a basic hospital policy written by itself, as has been the case with Blue Cross-Blue Shield when offering its Prolonged Illness Certificate ('PIC') as a supplement to its Major Medical Basic. Otherwise the supplementary policies would virtually have to be tailored, on a case-by-case basis, to whatever basic policies they are to apply, a rather difficult undertaking for the insurance industry which is accustomed to marketing policies which are uniform in nature.

84. In the light of these difficulties it may fairly be concluded that insurers willing to sell specified disease policies will be foreclosed from doing so unless they market basic hospital policies as well. The field will be limited to those willing to put out a combination package. For all practical purposes, the free-standing specified disease policy will be a thing of the past.

85. In conclusion, the petitioner's contention that the provisions of 47.07(1)(d) limiting the sale of specified disease policies to those which supplement a basic hospital insurance policy, particularly when made subject to the other stringent requirements of 47.07(1), constitute an arbitrary, capricious, and unreasonable regulation are well founded. The Court agrees.

* * *

86. In their Petitions both *American* and *Union* contend that Regulation 47.07(1), relating to specified disease coverage, *exceeds the scope and purposes of its parent statutes*, is not necessary to assure industry compliance with G.L. c. 175, §§ 108 and 110E, and should therefore be declared invalid and unenforceable.[35]

87. Section 108 of Chapter 175 is an omnibus statute which was enacted for the purpose of regulating the sale of 'accident and sickness' insurance policies in the Commonwealth of Massachusetts. It deals mainly with matters of form rather than substance.[36] It is basically a 'file and use' law which

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[35] American Petition ¶ 11; Union Petition Count I.

[36] Subsection 1 of section 108 deals with definitions. Subsection 2(a) requires insurance carriers to file copies of their policies, rates, schedules, and risk manuals with the Commissioner in advance, and prohibits their sale unless approved by the Commissioner or unless deemed to be approved if he fails to act within 30 days. Where the Commissioner issues a notice of disapproval he must give a statement of reasons as to why in his opinion the policy form does not comply with the laws of the Commonwealth. Any such negative ruling is subject to judicial appeal. Subsection 2(a) additionally lists certain mandatory subject matters which all policy forms must cover. Subsection 2(b) relates to sales to nonresident purchasers. Subsection 3(a) sets forth 12 types of provisions which must be printed 'verbatim' in all policies unless equivalent language is approved by the Commissioner in place thereof. Subsection 3(b) sets forth 11 types of provisions which, if covered by the policies, must be expressed in the language of the statute or equivalent language, which has received the Commissioner's approval. Subsection 3(b½) relates to insurers' reservations of right to refuse renewal. Subsection 3(c) relates to the manner in which an insurer may handle provisions of the statute which are inapplicable to a particular form of policy. Subsection 3(d) prescribes certain printing specifications. Subsection 3(e) relates to a matter of definition. Subsection 3(f) relates to matters of interstate comity. Subsection 3(g) authorizes the Commissioner to issue certain regulations. Subsections 4(a) and (b) state that policies which do not comply with the requirement of subsection 3 shall be held invalid but shall be enforced in accordance with the provisions of the statute. Subesection 4(c) relates to the filing of claims. Subsection 5 relates to a purchaser's appli-

allows the insurer to file a policy form, which places the burden of disapproval on the Commissioner, which requires him to act within thirty days, which obligates him to state the reasons for his disapproval if any, and which limits the scope of his discretion to specific instances of statutory non-compliance on the part of the insurer. Except for subsection 8A, the text of section 108 does not open the door for the rejection of insurance policy forms on the basis of many of the substantive reasons later incorporated in Regulation 47.

88. Subsection 8A authorizes the Commissioner to disapprove an insurance policy form only "if the benefits provided therein are unreasonable to the premiums charged." Nor does this grant of power stand alone, for it is subject to a concomitant right in the insurer to protect the decision, to be heard on the matter, and to seek judicial review. *See* subsections 8A, 8B, and 8C.

89. The readability statute (c. 175, § 2B) which is not challenged in this litigation, like section 108 is also a 'file and use' law, and in like manner to section 108 provides for judicial review in any case where the Commissioner disallows a policy form for non-compliance with the statute. *See* section 1 of section 2B.

90. Section 110E of Chapter 175 relates solely to the promulgation of rules and regulations for the sale of issuance of accident and sickness insurance policies, a procedural matter. Except insofar as it alludes to matters of substance in the formulation of regulations, it adds nothing of substance itself to the statutes governing the sale and issuance of such policies. It will be considered in further detail below.

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cation for insurance coverage. Subsection 6 relates to claims and proofs of loss. Subsection 7 relates to policy terminations by reason of the age of the insured. Subsection 8 (1st paragraph) lists types of insurance policies to which section 108 does not apply. Subsection 8 (2nd paragraph) refers to optional benefits. Subsection 8A, B & C is discussed above.) Subsection 9 refers to printing specifications.

91. A reading of Regulation 47.07(1) suggests that it goes far beyond the statutory bounds of section 108. No support can be found in section 108, expressly or by implication, for those provisions of 47.07(1) which give the Commissioner the unfettered power to outlaw any specified disease policy which does not include all twelve classifications of diseases outlined in 47.07(1)(a), which establish a minimum coverage of $10,000 and a daily minimum rate of $150 for those policy forms which are allowed, which sanction only those specified disease policies which are written to supplement basic hospital insurance policies, and which require guaranteed renewability at no increase in premium to age sixty-five.

92. The restrictive provisions of Regulation 47.07(1) are not identified, in the same sense of section 108 subsection 8A, as regulation adopted for the purpose of eliminating policies whose "benefits are unreasonable . . . [in relation] . . . to the premiums charged." They simply condemn policies which the Commissioner deems unreasonable.

93. There is a reasonable doubt that in enacting section 108 the legislature intended the agency to intervene in the affairs of individual accident and sickness policies to the extent prescribed in Regulation 47. A regulation must stay within the bounds of its enabling statute, least a power to regulate in the hands of a well-intentioned but over-zealous agency becomes a power to destroy. *Consolidated Cigar Corp. v. Department of Public Health, supra.* Commonwealth v. Racine, 372 Mass. 631; 363 N.E.2d 500 (1977). *Commonwealth v. Diaz*, 326 Mass. 525, 95 N.E.2d 666 (1950). *Finkelstein v. Board of Registration in Optometry*, 370 Mass. 476, 349 N.E.2d 346 (1976).

94. Where an agency is vested with a broad grant of authority to effectuate the purpose of an act, the validity of a regulation adopted thereunder will be sustained so long as it is reasonably related to the purpose and object of the legislation. *Levy v. Board of Registration and Discipline in*

Medicine, supra. Consolidated Cigar Corp. v. Dept. of Public Health, supra. School Committee of Springfield v. Board of Education, 362 Mass. 417, 287 N.E.2d 455 (1972).

95. Where the enabling legislation is narrow or limited in scope, or where its bounds are specifically outlined, a regulation must remain within its ambit to survive judicial challenge. *Finkelstein v. Board of Registration in Optometry, supra. Commonwealth v. Diaz, supra.*

96. In the judgment of the Court subsection 47.07(1) of Regulation 47, insofar as it permits the Commissioner to condemn specified disease policies which are not in compliance with the terms of the subsection, yet without making any provision for a right of protest, a right to be heard, and a right of judicial review, appears to overflow the bounds of section 108 and to have no rational relationship to any relevant statutory purpose.

* * *

97. In their Petitions both *American* and *Union* contend that Regulation 47.07(1), relating to specified disease coverage, *exceeds the regulatory authority of the Commissioner* under G.L. c. 175, §§ 108 and 110E and should therefore be declared invalid and unenforceable.[37]

98. Section 2 of Chapter 30A of the general laws requires agencies seeking to promulgate regulations to include in their notice of public hearing "the statutory authority under which the action is proposed."[38] Here the notice of the public hear-

[37]American Petition ¶ 10; Union Petition Count I.

[38] Section 3A of Chapter 175 of the General Laws does not vest the Commissioner with broad rule-making powers in the administration of his office. Reference must be had to the various sections of c. 175 for the source of his regulatory authority in certain specific areas. Nor does c. 30A, § 2 vest him with unlimited rule-making power. Under § 2 he must identify in his notice of public hearing the particular statutes upon which he relies for the

ing to be held on May 24, 1979 stated as follows: "In accordance with the authority granted to the Commissioner of Insurance under sections 2B, 108, and 110E of Chapter 176B; Chapter 176D; and Chapter 176E of the Massachusetts General Laws, a hearing will be held . . ." etc.[39] These must be examined to determine the scope and extent of the Commissioner's regulatory authority in this case.

99. Section 2B of c. 175 prescribes standards of readability with which insurance companies must comply. Except for subsection 47.05, none of the provisions of Regulation 47 appear to be based upon section 2B. Most certainly the provisions of 47.07(1) outlawing specified disease policies do not. Chapter 176 relates exclusively to fraternal benefit societies; Chapter 176A governs nonprofit hospital corporations; Chapter 176B, medical service corporations; and Chapter 176E, dental service corporations. Whatever the Commissioner's rule-making powers under these four chapters might be, they clearly have nothing to do with accident and health policies issued by private insurance carriers. Discarding the above as likely sources of authority for the adoption of Regulation 47, we are left with Chapter 176D and Chapter 175 §§ 108 and 110E as possibilities.

100. Chapters 176D was added to the general laws by Chapter 659 of the Acts of 1947. It was enacted to suppress "unfair methods of competition or unfair or deceptive acts or practices" in the insurance industry and to prohibit the "trade practices so defined or determined." The statute underwent change in 1972 and was completely replaced by the present Chapter 176D on the same subject matter.

101. Sections 3 and 4 of Chapter 176D describe a series of insurance company practices regarded by law as unfair methods of competition or as unfair or deceptive acts or prac-

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the promulgation of his proposed regulations. Enabling statutes not so identified, even where they exist, cannot be cited as support for his regulations under c. 30A § 2.

[39] Joint Exhibit 12 & 13.

tices. Section 11 empowers the Commissioner to "promulgate reasonable rules and regulations, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by sections three or four", but goes on to warn the Commissioner that such regulations "shall not enlarge upon or extend the provisions of said sections." Sections 6, 7, 8, and 9 of the statute spell out an insurer's due process rights of notice, hearing, and judicial review.

102. A review of Regulation 47 does not suggest that the Commissioner had Chapter 176D in mind when promulgating Regulation 47. Other than the indiscriminate reference to Chapter 176D in the antecedent notice of hearing, there is nothing in Regulation 47 which locks the regulation into the statutory provisions of Chapter 176D. Even though some of the provisions of Regulation 47 might be viewed as falling within the broad definitions of unfair or deceptive trade practices in Chapter 176D, the absence in Regulation 47 of the procedural and due process safeguards laid down in Chapter 176D is evidence that Regulation 47 was not in fact promulgated under the authority of Chapter 176 D, § 11. We now turn to an examination of c. 175, §§ 108 and 110E.

103. The one reference in section 108 to the adoption of implementing regulations appears in subsection 3(g) which states that the "Commissioner may make such reasonable rules and regulations concerning the *procedure* for the filing or submission of policies subject to this section as are necessary, proper, or advisable to the administration of this section" (emphasis supplied). Limited as it is to procedures for the filing and submission of policies, the scope of this enabling statute does not pave the way for regulations governing the substantive terms of accident and health policies.

104. Section 110E of Chapter 175 outlines the Commissioner's regulatory authority on the matter of accident and health policies in greater detail. Essentially it states that he

may issue regulations in two specific areas, (1) standards of full and fair disclosure, and (2) advertising. With respect to the first of these two areas of control, the section reads that he may "make rules and regulations... to establish minimum *standards of full and fair disclosure*, for the form and content of policies of accident and sickness insurance..." (emphasis supplied). The statute then goes on to say that such shall be made to bring about (a) reasonable standardization and simplification of coverages to facilitate understanding and comparison, (b) elimination of provisions which may be misleading or unreasonably confusing, (c) elimination of deceptive practices in connection with the sale of such insurance, (d) elimination of provisions which may be contrary to the health care needs of the public, and (e) elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders thereof.

105. Under a literal reading of the statute, the Commissioner's power is solely to establish minimum standards of full and fair disclosure for the form and content of policies. The objectives denominated in clauses (a) through (e), which the regulations are to "bring about", are subordinate to the dominate purpose of setting minimum standards or full and fair disclosure for policy form and content.

106. Conceding that his grant of authority could have been less ambiguously phrased, the petitioners insist that the Commissioner has read much more into the statute than is warranted. He has erred, they say, in construing the statute as giving him the unfettered power to dictate the substantive terms of accident and health policies, even to the extent of effectively precluding their further sale.

107. The petitioners argue that the Commissioner's regulatory function is merely to see that the policy forms are clear, understandable, and not misleading. He may not, they say, under color of the statute, regulate the coverages of the policies except insofar as his regulation is a reasonable means

toward obtaining full and fair disclosure. Thus, for example, he might require a particular definition of heart disease or cancer, whether in a single disease or a more general policy, in order to achieve standardization or simplification of coverages and facilitate understanding and comparisons. He might standardize permissible exceptions, waiting periods, and claims procedures to eliminate misleading or confusing provisions. He might mandate certain marketing procedures to eliminate deceptive practices. Presumably, he might prohibit, for example, a limitating provision which by its lack of clarity might provide a disincentive to the obtaining of medical care, as contrary to the health care needs of the public. Regulations of this type might be wholly consistent with his limited grant of statutory authority to set standards for full and fair disclosure.

108. Where, in the second part of the section 110E, the legislature granted a rule-making power unrelated to full and fair disclosure, it had no difficulty in doing so with unmistakable clarity. Section 110E contains a wholly separate enabling authority with respect to advertising.

> "The commissioner shall make . . . reasonable rules and regulations . . . concerning advertising of insurance policies . . . Such regulations shall contain, but not be limited to, the following principles: . . ."

Sixteen enumerated principles then follow governing the advertising of health, accident, and disability policies.

109. The parallel construction in these distinct portions of section 110E is significant. In each case there is a grant of rule-making authority with respect to a single, defined subject matter (full and fair disclosure on the one hand, and advertising on the other) followed by enumerated subsidiary considerations related to the same subject matter, items (a) through (e) implementing full and fair disclosure, and principles (1) through (16) setting specific requirements for insurance advertising. It would appear that items (a) through

(e) are plainly limited to the lone purpose of attaining full and fair disclosure for the form and content of policies.

110. The text of Regulation 47 reflects the liberal view of the Commissioner, presently under attack, that the objectives set forth in clause (a) through (e) are not merely subsidiary means for achieving the primary statutory purpose of full and fair disclosure but are themselves grants of independent and substantive powers which the Commissioner may use to issue regulations unrelated to the setting of disclosure standards.[40] Such a reading does violence to the normal rules of syntax and the plain meaning of the words used. "It is well settled that when a statute is construed its words are to be given their usual and ordinary meaning considered in light of the aim to be accomplished by the Legislature." *Prudential Insurance Compan of America v. Boston*, 369 Mass. 542, 546 (1976).

111. It is also of interest to note that Regulation 42 (Joint Exhibit 8) was far less ambitious than Commissioner Sabbagh's later venture into the substantive realm of insurance policies by means of his Regulation 47. Although Regulation 42 was also adopted after the effective date of section 110E,

[40] The purpose clause in 47.01 belies the Commissioner's liberal interpretation of the enabling statute. It contains no suggestion that the regulation shall deal with matters of policy substance. Essentially it delcares that the regulation is intended to provide for full disclosure of policy contents, to eliminate misleading and confusing provisions, to minimize deceptive sales practices, etc. A comparison of the final purpose clause with the original text of the proposed purpose clause (*see* Joint Exhibit 14 and Defendant Exhibit 3) is revealing. The two are substantially the same, except that the first draft included a clause which declared as one of the purposes "to curb the sale of coverages which are so limited in scope as to be of no substantial economic value to the policyholder." This was watered down in the final version, possibly because of an apprehension that it went too far, to the clause which now reads "to establish standards by which to judge the reasonableness of benefits in relation to premiums." The current litigation attacks the Commissioner for failing to water down the body of his regulation as he did the purpose clause.

the then Commissioner Ryan resisted any temptation to regulate the substantive provisions of accident and sickness policies to the extent later attempted by Commissioner Sabbagh. The purpose clause of Regulation 42 reflects Commissioner Ryan's more conservative view that his authority was limited to matters of form and procedure and did not reach matters of substance.

112. The legislative history of section 110E supports the petitioners' conservative interpretation. The section was added by St. 1973, § 1081. In the 1973 legislative session, the Division of Insurance recommended the passage of House Bill No. 108 which would have amended c. 175, § 108 by adding a new final paragraph as follows:

> "The Commissioner may require any company to file with him all advertising and sale promotional material it proposes to use in connection with the sale of any accident or sickness policy and may order such material not be used if it is, in his opinion, misleading or deceptive. The Commissioner may also by regulation *establish minimum benefits for accident and sickness policies* sold in this Commonwealth so as to prevent the sale of policies that *he finds* are not of substantial economic value to the policy holder." (Emphasis supplied).

113. Had House Bill No. 108 passed, the substantive restrictions on specified disease policies contained in 211 C.M.R. 47.00 *et seq.* might have fallen within the Commissioner's power.[41] Needless to say, House Bill 108 was not enacted.

114. Later in the same session, House Bill No. 7319 was introduced, in substitution for an earlier bill which itself had been substituted for House No. 108. House No. 7319 bears a strong resemblance to the first part of section 110E but for

[41] The language of House No. 108 refers to the prevention of sale of policies that the Commissioner finds are not of substantial economic value. Section 110E, clause (e) speaks of the elimination of *coverages which are so limited in scope* as to be of *no* substantial economic value.

one crucial difference. The earlier language empowers the Commissioner to "make . . . reasonable rules and regulations . . . to establish minimum standards, *including* standards of full and fair disclosure, for the form and content of policies of accident and sickness insurance . . . Such rules and regulations shall be made to bring about: [items (a) through (e) as in the final enactment]." (Emphasis supplied). Under the earlier draft the Commissioner could have set general standards for the form and content of such policies, *including but not limited to* standards of full and fair disclosure. In the final enactment, however, that grant was cut back, and he is now limited to making regulations "to establish minimum standards of full and fair disclosure" only.[42]

115. All in all, one may reasonably conclude that the Commissioner's regulatory authority under c. 175 §§ 108 and 110E is quite limited in scope and does not include the power to issue substantive regulations so restrictive in nature that they effectively ban the sale of specified disease policies without right of judicial review.

116. It appears that many of the provisions of Regulation 47.07(1) which are substantive in nature go far beyond the scope of the Commissioner's limited regulatory authority under G.L. c. 175, §§ 108 and 110E. In particular, the outright ban of any specified disease policy which fails to include all twelve categories of diseases listed in 47.07(1)(a), no more and no less, can hardly be viewed as a regulation relating to "the procedure for the filing and submission of

[42] Reference may be made to the State of New York for a 1971 statute on the same subject matter. New York statutes § 174(a) provide that "the Superintendent shall issue such regulations as he shall deem necessary or desirable to establish minimum standards, including standards of full and fair disclosure, for the form, content, and sale of accident and health insurance . . ." The choice of a different wording by the Massachusetts legislature must be assumed to have been with good reason. The contrasting language should not be deemed a distinction without a difference.

policies" under section 108, 3(g), or as a regulation "establishing minimum standards and fair disclosure" under section 110E.

117. If in fact a twelve-disease policy can be framed in a non-deceptive and non-misleading manner, so too can a single-disease policy be drawn. There is nothing magic about the number twelve which would tend to qualify a twelve-disease policy as one of full and fair disclosure and anything less as not. No logical reason appears why a standardized or simplified specified disease policy may not be made fully understandable and readily comparable to other specified disease policies, or to the relevant enumerated coverages in a more general policy. Likewise, no reason appears why a specified disease policy may not be written free of misleading or unreasonably confusing provisions.

118. Subsection 47.07(1)(a) and (b) setting a minimum overall benefit of $10,000 and minimum daily benefits of $150 or actual cost whichever is less, also appears to exceed the Commissioner's regulatory authority under sections 108, 3(g) and 110E.[43]

119. Subsections 47.07(1)(c) mandating that all specified policies be guaranteed renewable to age 65 at no additional cost, etc., likewise appear to exceed the scope and purpose of the Commissioner's regulatory authority under sections 108, 3(g) and 110E, and indeed they clash with subsections 3(a)(3) and 3(b½) of section 108 which recognize non-renewability as a permissible feature of accident and health policies.

120. In similar respects, subsection 47.07(1)(c) prohibiting the sale of specified disease policies to anyone over 65 and

[43] Although Regulation 42 (Joint Exhibit 8) contains minimum benefit restrictions as well as other restrictions of a substantive nature less extensive in scope than Regulation 47, and although it might be subject to full or partial challenge as in the case of Regulation 47 here, the petitioners have apparently accepted its terms and have decided to live with it. Aware that Regulation 42 may represent the camel's foot in the tent opening, the petitioners have decided to stand and fight on Regulation 47.

subsection 47.07(1)(d) prohibiting the sale of specified disease policies except as a supplement to a basic hospital insurance policy appear to exceed the bounds of the Commissioner's parent statutes and his regulatory authority under the enabling statutes.

121. Summarizing, it may fairly be said that the provisions of Regulation 47.07(1) exceed the scope and purposes of the parent statutes and the Commissioner's regulatory powers thereunder. They deal with the substantive provisions of accident and sickness policies, not just with procedural matters. They do not limit themselves to the "filing and submission" of insurance policy forms under section 108, nor to "minimum standards of full and fair disclosure" under section 110E. Quite unabashedly they purport to regulate the risks insured against, the minimum benefits that must be provided, the length of time during which said benefits must be available, and the relationships between specified disease insurance and basic hospital insurance policies.

122. Lastly, in vesting the Commissioner with the ultimate power of disapproval, yet with no specific provisions for rights of due process in the insurers affected, they are in direct conflict with the provisions of section 108, subsection 8A, B, and C. Regulations may not erase a practice expressly permitted by an enabling act. *Purity Supreme Inc. v. Attorney General, supra.*

123. Conceding that there may be a need to protect the insurance consumer from callous industry practices, the arbitrary and draconian measures of Regulation 47 are nonetheless not needed. The consumer is reasonably well protected by the statutes, and he can be further protected by regulations promulgated within the scope of the enabling law. Subsection 8A Chapter 175 entitles the Commissioner to disapprove a policy if the benefits are unreasonable in relation to the premium charged, or if any provision is unjust, unfair, inequitable, misleading, or deceptive, or if misrepresen-

tation is encouraged, subject always of course to due process rights in the insurer. Further, the second half of section 110E imposes mandatory advertising safeguards. And Chapter 176D embodies a complete statutory scheme to deal with unfair methods of competition and with unfair and deceptive trade practices, again always subject to due process rights in the insurer. The stringent substantive requirements of Regulation 47.01(1) were not absolutely necessary to an accomplishment of the statutory scheme, although they may have been deemed advisable by agency personnel or by witnesses at the Commissioner's hearing who were displeased that the statutes had not gone far enough.

* * *

124. In their Petitions both *American* and *Union* contend that c. 175 § 110E should not be treated as authorizing regulations under which the Commissioner may withhold approval of accident and sickness policies, or withdraw approval of policies previously cleared by his office under c. 175 §, 108, *without first granting an adjudicatory hearing and a right of judicial review.* The petitioners further contend that any actions the Commissioners may have taken under the guise of section 110E or Regulation 47 to withdraw such prior approvals should be declared null and void.[44] In its Prayer *American* also asks that section 110E, insofar as it purports to allow the Commission to withdraw such prior approvals, be declared unconstitutional, invalid, and unenforceable.[45]

125. Although c. 175 § 108 does not permit the Commissioner to withhold or withdraw approval of an accident and sickness policy without giving the affected insurer due process rights of a notice, an adjuticatory hearing, and a right of

[44] American Petition ¶¶ 9, 13, and 14; Union Petition Counts IV and V.

[45] American Petition, Prayer #1.

judicial review,[46] sectin 110E is less specific on the matter of an insurer's rights. Not only may an insurer not issue a policy in violation of rules or regulations promulgated under section 110E, the second paragraph of that section states that the Commissioner may withdraw approval of any policy found not to be in compliance with regulations adopted under section 110E, and that he may to so whether his approval had been granted prior to or following the effective date of the applicable regulation, thereby endowing his regulations with a retroactive as well as prospective effect. Except for the statement in the second paragraph of section 110E that in the case of a withdrawal the Commissioner must give written notice of the reasons for his action, the statute affords no further relief to the insurer by way of hearing or judicial appeal. The Department has construed section 110E to this effect and now acts accordingly.

126. Whether the bare text of section 110E which contains inadequate rights of due process is to be read as overriding the due process provisions of section 108, or whether it is to be read in a more compatible sense, is in issue here.

127. Much the same issue arises under Regulation 47 itself. In contrast to the terms and provisions of Regulation 42 which 'grandfathered' previously approved policy forms,[47] even though it was adopted after the enactment of section 110 E, the text of Regulation 47 does no such thing. Subsection 47.02 of Regulation 47, both literally and as interpreted by the Commissioner, condemns all policies in conflict with the text of the regulation whether issued before or after its effective date. More specifically, subsection 47.07(1)(e) states that "any policy covering specified diseases must meet

[46] In the event of a disapproval, subsection 2(a) of section 108 provides for notice to the party and a right of judicial review. In the case of either a disapproval or a revocation of approval, subsection A, B, and C of subsection 8 grant rights of notice, an adjudicatory hearing, and judicial review.

[47] Sections 3, 4, and 25 of Regulation 42, Joint Exhibit 8.

the standards of 211 CMR 47.07(1)(a) through 47.07(1)(d); it may not be sold as Restricted Health Insurance as defined in 211 CMR 42.13."

128. It was stipulated by *Union* and the Commissioner for purposes of this litigation as follows:[48]

> "9. The Rules and Regulations purport to prohibit Union Fidelity from marketing the above approved dread disease and Medicare supplement insurance policies except for renewals of existing policies."
>
> "10. At no time has the Commissioner ever held an adjudicatory hearing on the issue of whether the Commissioner's approval of Union Fidelity's cancer insurance policies should be withdrawn."
>
> "11. The Commissioner has not withdrawn his approval of Union Fidelity's cancer insurance policies and Medicare supplement insurance policies by either individually notifying Union Fidelity in writing that said policies are not in compliance with adopted regulations, or by holding an adjudicatory hearing to determine whether the Commissioner's approval of said policies should be withdrawn."

129. Aggrieved by the impact of Regulation 47 on their specified disease policy forms which had been cleared for use prior to the adoption of Regulation 47, as well as by its impact on future sales, both *American* and *Union* argue that a retroactive application of Regulation 47 is in violation of their rights of due process. In brief, they allege that a regulation, even though adopted under color of section 110E, which authorizes the Commissioner to withdraw approval of a previously allowed health and accident policy without first giving them the express rights to notice, to an adjudicatory hearing, and to judicial review which are set forth in section 108, should be declared invalid and unenforceable.

130. The provision of subsection 47.09(5) of the regulation go only part of the way but not far enough. They provide that

[48] Joint Exhibit 15.

an insurer receiving notice of a "final disapproval" may request a hearing before the Division of Insurance within 10 days and that a hearing shall be granted by a hearings officer. But the matter ends there. A mere right of appeal to the very agency whose decision is being appealed, however, does not afford sufficient due process. *Goldberg v. Kelley*, 397 U.S. 254, 90 S. Ct. 1011, 25 L. Ed. 2d 287.

131. In the judgment of the Court section 110E of c. 175 should not be read as overriding the express grants of due process rights set forth in section 108, subsections 2(a) and 8A, B, and C. The two statutes may be read, and should be read, as constituting a logical and harmonious statutory scheme. If when enacting section 110E the legislature had intended to repeal the due process rights of section 108, it would have been expected to do so in clear and unmistakable terms. The fact that section 110E did not repeat in full the due process provisions of section 108 should not be construed as an implied repeal. Section 110E can be fairly read as prescribing additional requirements for health and accident policies while still retaining an insurer's right to contest an adverse decision of the Commissioner under the mechanisms of section 108. The Court has expressed a strong and abiding preference for the preservation of individual rights to an adjudicatory hearing and judicial review. *Cambridge Gas & Electric Company v. Dept. of Public Utilities*, 363 Mass. 474; 295 N.E.2d 876, 891-892 (1973).

132. When enacting section 110E the legislature was not unaware of the primary role of section 108, for in the second paragraph of 110E it is stated that policies governed by section 108 must henceforth comply with the substance of regulations promulgated under section 110E. The linkage was clear. To read section 110E as authorizing a regulation which would abrogate the due process provisions of section 108 would not only elevate a regulation to a status higher than that of a statute, it would do violence to the maxim that stat-

utes which impinge upon the property rights of individuals should be strictly construed.

133. It is the further judgment of the Court that the Commissioner is unwarranted in holding that previously approved health and accident policies, which do not now comply with the requirements of a section 110E regulation such as Regulation 47 in this instance, may be condemned for further sale or use without first offering the affected insurer the due process rights spelled out in section 108, and that any action he may have taken thus far to revoke the good standing of such policies would do violence to rights of constitutional due process and should be declared null and void.

134. What action the Court might take, in the event the Commissioner, acting as a hearings officer under section 108, elects to impose section 110E regulations retroactively, must be reserved for another day. The short answer now is that the petitioners have a right to such a hearing and that the hearing should be held.(*)

135. The view that bare terms of Regulation 47 should not be accorded a retroactive effect is supported by the history of its enabling legislation. House Bill 7319 of 1973, a predecessor to the current section 110E, reads as follows: "When a rule or regulation has been adopted pursuant to this section, all policies of insurance or subscriber contracts which are not in compliance with such regulation *shall, when so provided in such regulation, be deemed to be disapproved* as of a date specified in such regulation not less than sixty days following its effective date, without any further or additional notice other than the adoption of the regulation," (lines 27 through 33) (emphasis supplied). Yet this language was not carried forward in the final text. The statute now reads: "When a

(*) That is to say, an insurer aggrieved by a policy revocation under a section 110E regulation is entitled to a section 108 hearing when the regulation is valid and in good standing. Where a section 110E regulation is ruled invalid (*see* Final Order in this action) the need of a section 108 hearing may be moot.

rule or regulation has been adopted pursuant to this section and an individual policy . . . is not in compliance with such rule or regulation, such noncompliance *shall be grounds for* a withdrawal of approval of such policy form. . ." (emphasis supplied). The petitioners suggest that the language was changed to save their rights to an adjudicatory hearing under section 108 where disapproval is based upon noncompliance with a section 110E regulation such as Regulation 47 here. Conversely, the Commissioner's position with respect to the viability of previously approved policies is more in tune with the language of the House Bill that was abandoned than with the language of the statute as finally enacted.

136. The evidence also established that it is the current practice of the Commissioner, when reviewing policy forms for compliance with the readability statute (c.175, § 2B) to also screen them for compliance with Regulation 47 and to deny their use when in conflict with Regulation 47.[49] In so doing, the Commissioner finds support in the wording of the third paragraph of section 2B that he may approve policies under 2B "notwithstanding those provisions of any other laws which specify the content of insurance policies, *provided the approved policy assures to the policyholders and claimants protection no less favorable than they would be entitled to under such other law*" (emphasis supplied). As in the case of section 110E, the terms and provisions of section 2B should not be read as standing alone but should not be read in conjunction with section 108 to constitute a logical and harmonious whole. Neither section 110E nor section 2B should be construed as abrogating, by implication, an insurer's due process rights to notice, to a hearing, and to judicial review as spelled out in section 108.

* * *

[49] *See* Transcript III: 62-64.

137. In its Petition *Union* contends that Regulation 47 is invalid and unenforceable in its entirety for *failure of the agency to give Union prior notice of the regulatory hearing* to be held by the Commissioner on May 23, 1979, later amended to May 24, 1979.[50]

138. During the trial of the action counsel for both *Union* and the Commissioner filed a written stipulation of fact.[51] The stipulation stated in part as follows, and the Court so finds:

> "3. Union Fidelity did not receive the Notice of Hearing and did not receive any other form of individual notice as to the subject matter or conduct of said hearing held on May 24 and May 25, 1979."
>
> "4. Union Fidelity did not at the time of the hearing have on file at the Division of Insurance a written request for notice of agency rule making hearings."
>
> "5. Union Fidelity did not participate in the hearings held by the Commissioner on May 24 and 25, 1979."

139. Chapter 30A, § 2 requires that prior to a public hearing on the adoption, amendment or repeal of a regulation, notice be given (a) by publication; (b) by "notifying any person to whom specific notice must be given" by mail; (c) by notifying persons who have filed a written request for such notification with the agency; and (d) by filing with the Secretary of State.

140. Under date of April 27, 1979 a notice of a hearing on the proposed regulations, which were to be of general import, was issued by the Director of the Rate Setting Bureau, an entity operating within the Division of Insurance. The date of the hearing was later amended to May 24, 1979 by further notice dated May 1, 1979. The notice as amended was duly published in the May 3rd editions of the Boston Globe and the Springfield Morning Union. In addition, copies of the notice

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[50] Union Petition Court II.

[51] Joint Exhibit 15.

were sent to about twenty-five individuals or organizations, both public and private, viewed by the Division as interested parties. With the exception of the Blue Cross-Blue Shield organization, no notices were sent directly to insurance carriers.[52]

141. Among those to whom the notice was sent was the Health Insurance Association of America, 919 Third Avenue, New York City, an organization of about 400 members nationwide.[53] A notice also went to the 'Standard' a weekly publication of health insurance industry with distribution in Massachusetts.

142. It was indicated in the notice that copies of the proposed regulation could be viewed in the office of the Division of Insurance. Copies of the notice and of the notice amendment were introduced by the parties during the trial of the action.[54] The operative paragraph reads as follows:

> "The hearing will consider a proposed regulation governing individual accident and sickness policies and subscriber contracts. The proposed regulation would set standards for 'Medicare Supplement' policies, implement the 'readable policy' law (M.G.L. c. 175, § 2B), establish premium rate standards for all policies, provide rules for the filing of all policies, eliminate policy provisions contrary to the health care needs of the public, and set other rules for the conduct of this line of business. Issues to be considered include whether Medicare Supplement standards should set one or more benefit levels and whether these levels should be minimums or fixed levels."

143. Conceding that it had never filed a request for notice under the statute, *Union* nonetheless contends that it should have received direct notice as an interested party or as a

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[52] For complete list of addresses, *see* Defendant Exhibit #1.

[53] It was stipulated by Union and the defendant that Union has never been a member of the 'HIAA'. *See* Defendant Exhibit #7.

[54] Joint Exhibits 12 and 13.

"person to whom specific notice must be given" as noted in the statute. In the presentation of its case, *Union* advanced a number of reasons why, in its opinion, it should have been a direct addressee of the notice.

144. As a writer of specified disease policies and medicare supplement policies which had been certified for sale in Massachusetts, *Union* claims it should have had direct notice of the hearing. To consider the validity of Union's position in this respect, one must know something about the volume of work processed by the Division of Insurance.

145. As of 1979 there were about 360 companies licensed to sell health insurance in the Commonwealth. The flow of paperwork through the Division has been staggering. The policy review section is required to process about 5,000 insurance forms a year. The forms that have cleared through the Division in recent years number in the tens of thousands.

146. When Regulation 47 was under consideration in 1979 the Division did not maintain an index of insurance carriers licensed to do business in the State for the sale of specified disease policies or medicare supplement policies 'per se.' Documents which came to the agency were recorded in chronological order in voluminous log books. As of 1979 the log books contained references to about 50,000 separate health insurance forms, including such items as policies, riders, endorsements, applications, etc.

147. Prior to 1972 the log book system merely reflected the name of the insurer, the form number of the item, the nature of the document as for example a policy or a rider, the date received, the date approved or disapproved, whether a 'deemer' letter was issued, etc. It was not possible to tell anything further from the log itself. Reference would have to be made to the document files to find out whether an item was a life or health policy for example, or whether it was a group or individual policy, or if it was a health policy whether it was a basic hospital policy, a dread disease policy, etc. After the

year 1972 the logging system was changed to a more sophisticated type, but from 1949 to 1972 the situation was as above described.

148. Although it was a relatively simple matter to locate a document once given the name of the insurer, the form number, and the date of filing, the reverse would not have been true. For to develop a list of all approved policies of a particular type, such as dread disease policies, would have involved a back-breaking search through the log books and then into the document files themselves.

149. To further complicate the matter, beginning in 1975 and extending through 1978 the Division crated and shipped about 90 to 100 boxes of forms to the State archives agency for storage in Walpole or South Boston, or in Grafton. This was made necessary by lack of space.

150. In short, the petitioners' assumption that the Division could easily have prepared an accurate and complete list of all approved dread disease insurance carriers to whom notice of the May 1979 hearing could have been given was and is unfounded, as is also their expectation that the Division could have done so for purposes of the trial of this action.[55]

151. Nonetheless, the petitioners point out, and rightly so, that the Director of the Rate Setting Bureau who set up the hearing of May 1979 and who sent out the notices could have notified some of the dread disease insurance carriers, if not all, had he paused to check with the head of the policy approval section who had recently prepared partial lists of such carriers on an 'ad hoc' basis. It was shown on the evidence that the policy approval office had prepared a list of dread disease insurers at the request of the Commissioner in July of 1979 in connection with work in which the Commissioner was then engaged on the readability law, c. 175, § 2B. Although

[55] *See* Petitioners' Subpoena duces tecum and Report of the head of the policy approval section to the trial justice relative thereto. Petitioner Exhibits 9 and 20.

the list had nothing to do with the Regulation 47 matter, it was assembled after the date of the May 1979 hearing on Regulation 47 and before the date of its enactment in September of that year, hence fairly contemporaneous. Because of the difficulty if not the impossibility of preparing such a list from the records of the Division, it was accomplished with the aid of information obtained at the Insurance Library Association at One Beacon Street, Boston. As prepared, it was merely a list of insurance carriers licensed to do business in Massachusetts who also market specified disease policies. It did not purport to be a list of companies which had actually received specified disease policy approvals in Massachusetts—only those who might have received such approvals. But it was a start. The list was among the exhibits introduced in evidence during the trial of the case.[56]

152. A second such list recently put together by the policy approval section in late 1978 hit closer to home since it was indeed a list of dread disease carriers who had received approval of their policies from the Division of Insurance during the period 1973 through 1977. Again, it had nothing to do with the Regulation 47 matter. It was prepared at the request of the Director of the Rate Setting Bureau in connection with some rate schedule work then underway. No effort was made to make the list a complete one, nor did it contain any data on policies approved before 1973. Yet *Union* was among the companies appearing on the list, and as pointed out by *Union*, the list could have been used as a basis, at least in part, for notice to the dread disease insurance industry of the hearings to be held on May 24, 1979. The list was among the items introduced in evidence during the trial.[57]

153. What is perhaps more to the point, the Division of Insurance initiated a market conduct examination from October 1977 to June of 1979 of certain companies engaged in

[56] Petitioner Exhibit 1.
[57] Petitioner Exhibit 3.

the sale of cancer insurance policies in Massachusetts, specifically American, Union, American Income, and Washington National. The examinations of the four were conducted on site, with members of the respective survey teams actually traveling to the home offices of the companies in their respective states.

154. Upon completion of the examination, the Research and Education section of the Division prepared a study on cancer insurance, utilizing the results of the market conduct review along with other data. Without any measure of doubt, the dread disease portions of the subsequently adopted Regulation 47 were influenced, if not actually motivated, by the Research and Education study report. For this reason alone *Union* argues the four companies subjected to the examination should have been singled out for direct notice of the May 24th hearing, to say nothing of whether notice should have been given to other dread disease companies. Understandably Union's grievance is not without merit.

155. A glance at the list of addressees to whom direct notice of the hearing was sent[58] shows a pronounced tilt toward consumer oriented persons or agencies who might well be expected to support any effort of the Division to rid Massachusetts of single disease insurance policies if shown to be detrimental to consumer interests. Conversely the agency seems to have relied upon its notice to the 'HIAA' and the 'Standard' as adequate notice to the insurance industry, perhaps in the expectation that the Association would give further notice to its own membership, or that notice might hop from one carrier to another by word of mouth.

156. Although the publication of a notice in the small print legal notice section of a newspaper may often comply with the letter of the law, the Court well understands Union's position that undue reliance on such manner of notice may not be the best affirmative means of assuring actual notice and that

[58] Defendant Exhibit 1.

it may in fact be calculated more to defeat than achieve actual notice, particularly where it burdens the nationwide insurance industry with the obligation of monitoring newspaper ads in all fifty states and on all lines of insurance to make sure that one's right to market a form of insurance in any one state is not lost through lack of attention.

157. The Court does not disagree with *Union* that it would have been a simple matter for the agency to have at least mailed direct notice to the four companies who had been targeted by the market survey conducted in the two-year period just prior to the 1979 hearing, noting by the way that when Regulation 42 was advertised in 1974 the agency mailed about 500 letters of notice to individual insurance companies, presumably without any great difficulty. The change in procedure from 1974 to 1979 may regrettably have resulted from the fact that the policy approval section was deeply involved in the handling of the 1974 case, whereas in 1979 the undertaking was under the control of the Rate Setting Bureau of the Division of Insurance with the policy approval section somewhat out of the picture.

158. The Court recognizes, in response to Union's argument, that the management of the 1979 notice matter may have been ill conceived or poorly executed, that it may have reflected an agency indifference to the wisdom of directing actual notice to insurance carriers who would obviously be affected, and that it may in fact have manifested an unbecoming anti-company pro-consumer attitude on the part of the agency itself or its personnel.

159. In contending that *Union* cannot be heard to complain for lack of actual notice, the defendant points out that *American* was present and participated in the proceedings, that it must have informed its friend *Union* that they were taking place, and that even if that was not the case, Union's interests would have been well represented by American's involvement. The Court does not agree. The issue is not simply

one of determining whether the party entitled to notice had actual or constructive notice or none at all, but whether the agency charged with the responsibility complied with the laws relative to notice and whether the parties entitled to receive it did receive it in proper fashion. Statutory requirements as to notice must be strictly observed. *Co-Ray Realty Co. v. BZA of Boston*, 328 Mass. 103, 101 N.E.2d 888 (1951).

160. The function of the Court however is not to tell the agency how to mind its own business or how to exercise its discretion, no more than it is the function of the agency to dictate the behavior of the Court. The test on judicial review is merely to determine whether the agency has complied with the letter and the intent of the law, and no more. It is not for the Court to say that because the agency could have given direct notice to *Union* it was required to do so. The rule is to determine not what the agency could have done, but what is should have done.

161. G.L. c. 30A, § does not define what is meant by "a person to whom notice must be given." Clearly it would embrace any party specifically nominated in a general or special law as a person to whom direct notice of a particular regulatory hearing under c. 30A must be given. No such statute was called to the Court's attention during the trial of this action, nor is the Court aware of any.

162. It is the final judgment of the Court, having given due attention to the evidence and the arguments of the parties, that the Division of Insurance was not required to affirmatively search out and identify all health and accident insurers who might be affected by the proposed Regulation 47 for the purpose of giving them direct notice of the May 1979 hearing, nor was it required to give direct notice to the petitioner *Union*. Helpful though it might have been, such an undertaking was not mandated by law or by the express terms of c. 30A, § 2. Union's contention that Regulation 47

should be declared invalid and unenforceable in its entirety for lack of notice to *Union* is rejected.

* * *

163. In its Petition *Union* contends that the notice of the regulatory hearing to be held on May 23, 1979, later amended to May 24, 1979, did not comply with the requirements of G.L. c. 30A, § 2 for failure to show that items would be proposed or considered which would effectively ban the further sale of cancer insurance in Massachusetts and cause withdrawal of previously approved cancer policies, and *for not stating the express terms or* the substance of said proposed regulations.[59]

164. *Union* further contends that the notice did not say that items would be proposed which would ban further sale of the type of medicare supplement insurance sold by *Union* in Massachusetts or cause withdrawal of prior approvals of such policies, that it did not identify the subject matters to be considered at the hearing, and that it did not state the express terms or the substance of said medicare regulations.[60]

165. Accordingly, *Union* contends that Regulation 47 should be declared invalid and unenforceable in its entirety.

166. During the trial of the action Counsel for both *Union* and the Commissioner filed a written stipulation of fact.[61] The stipulation stated in part as follows, and the Court so finds:

> "6. At no time has Union Fidelity ever received individual notice from the Commissioner that the Commissioner was holding a hearing to consider the adoption of a regulation that would ban the type of cancer insurance marketed by Union Fidelity in Massachusetts, except for renewals of existing policies."

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[59] Union Petition Counts II, III, and VI.
[60] Union Petition Counts II, III, and VIII.
[61] *See* Joint Exhibit 15.

"7. At no time has Union Fidelity ever received individual notice from the Commissioner that the Commissioner was holding a hearing to consider the adoption of a regulation that would ban the type of Medicare supplement insurance marketed by Union Fidelity in Massachusetts except for renewals of existing policies."

167. Chapter 30A, § 2 reads that the notice "shall ... either state the express terms or describe the substance of the proposed regulation..." In support of its position *Union* argues that no prudent or rational individual would suspect from a reading of the notice of the proposed regulation that it would eliminate single disease policies, or that it would require all specified disease policies to include the wide coverage set forth in the Commissioner's ultimate twelve-item grouping, or that they could be sold only as supplements to a basic hospital policy, or that minimum dollar limits would be set as ultimately proved to be the case. Nor would a person be expected to realize, argues *Union*, that new and different medicare supplement regulations would be forthcoming which would render the former regulations obsolete, and which would render Union's current medicare supplement regulations no longer salable. The Court does not agree.

168. It is recognized that the notice emphasized the matter of medicare supplement regulations and the implementation of the readability law, and that it was remarkably quiet about the prospect that specified disease policies would be a major topic of consideration. The Division could certainly have done a better job. But it is also clear that in the case of an extensive regulation its scope cannot be fully spelled out in the notice. The notice need only describe the substance of the regulation. Essentially it should alert the public to the topics that will or might be considered.

169. In the judgment of the Court the notice in this case squeaks through. It stated that "individual accident and sickness policies" would be considered. The term 'accident

and sickness insurance' is defined in the first paragraph of c. 175, § 108, and it appears throughout the text of section 110E and the previously adopted Regulation 42. Although it failed to make specific mention of specified disease insurance as one of the items to be reviewed, it invited interested parties to see the draft of the regulation in the office of the Division of Insurance. This was a proper and useful technique, and it was appropiate here since the draft can speak for itself. Had no mention of the availability of the draft been made, or if the draft had failed to mention that medicare supplement insurance and specified disease insurance would be among the topics under consideration, the petitioners here might well be aggrieved.

170. Turning to the draft itself, section 6.3b, although vaguely worded, should have been sufficient to alert dread disease insurers that something drastic was brewing.[62] It read as follows:

> [No] "policy may contain coverage conditioned upon a covered person's having any specifically named or described disease, nor may policies otherwise describe benefits to achieve this result, unless the policy covers most or all diseases or conditions of similar severity and cost."

171. Further, section 7.1 of the proposed regulation dealing with medicare supplement insurance spanned three-plus pages of typewritten text to such an extent that one could not now say that the incorporation of a medicare supplement insurance section in the final regulation was a complete surprise.

172. The fact that the terms and provisions of Regulation 47 as finally adopted did not duplicate or even closely parallel the text of the proposed regulation in those areas under challenge in this litigation is not fatal and does not render the target regulations invalid and unenforceable. Changes can be

[62] Joint Exhibit 14 ¶ 6.3b at page 4.

made in a proposed regulation as long as they are not "so extensive as to make the regulation in effect a different regulation from the one as to which the proceeding was held.... The requirement of submission of a proposed rule for comment does not automatically generate a new opportunity for comment merely because the rule promulgated by the agency differs from the rule it proposed, partly at least in response to submissions.... A hearing is intended to educate an agency to approaches different from its own; in shaping the final rule it may and should draw on the comments tendered." *Grocery Manufacturers of America v. Department of Public Health*, 379 Mass. 70, 393 N.E.2d 881 (1979). The final regulation need only be "a logical outgrowth of the hearing and related procedures." *Grocery Manufacturers of America, supra*. The contention of the parties that Regulation 47 should be declared invalid and unenforceable for lack of sufficiency of the content of the notice is rejected.

* * *

173. In its Petition *Union* contends that there was *no evidence to support* the 'Opinion, Finding, and Decision' of the hearings officer[63] dated September 17, 1979 that subsection 47.07(1), which purports to ban the sale of cancer insurance, was necessary to accomplish the purposes of c. 175, § 110E(a) through (e); that the adoption and issuance of said subsection was therefore unsupported by substantial evidence, was based on error of law, was arbitrary, capricious and an abuse of discretion; and that said subsection should therefore be declared invalid and unenforceable.[64]

174. For the same reasons *Union* contends that the medicare supplement provisions of Regulation 47 should be declared invalid and unenforceable.[65]

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[63] Milton G. McDonald, Deputy Commissioner and Actuary.
[64] Union Petition Count VII.
[65] Union Petition Count IX.

175. Thirdly, and for the same reasons, *Union* contends that subsection 47.09(4), which purports to establish policy and rate filing and review standards should be declared invalid a unenforceable.[66]

176. The Court interprets Union's complaint to mean that the evidence introduced at the hearing was insufficiently to warrant the report of the hearings officer and the regulations that were subsequently adopted, and not as a complaint that the evidence introduced in the trial of the action was insufficient to support either the hearings officer's report or the regulation itself.

177. Quite apart from whether an agency regulation promulgated under c. 30A, § 2 can be challenged in litigation of this nature as unsupported by evidence before the hearings officer under the rule more commonly applied in the case of adjudicatory hearings,[67] both *American* and *Union* resisted all efforts of the defendant to introduce the record of the proceedings of the May 24th hearing, including the Transcript of those hearings, to rebut the charge that the regulation was not bottomed upon substantial evidence.[68] The items constituting the record of proceedings of the May 24th hearing were excluded by the Court upon objection of both *American* and *Union*. They were marked Defendant Exhibits for identification 'C' through 'Z' and 'AA' through 'NN'. As to those which the Court accepted 'de bene' subject to later rulings, they are now excluded. By reason of their unwillingness to have the Court review the May 24th proceedings, the Court deems the objections of both *American* and *Union* to the sufficiency of the evidence introduced in those proceedings to have been waived.

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[66] Union Petition Count X.

[67] *See Grocery Mfgrs. of America v. D.P.H.*, 379 Mass. 70, 393 N.E.2d, 881 at 890, West Key Nos. 16-19. *Greenleaf Finance Co. v. Small Loans Regulatory Board*, 377 Mass. 282, 385 N.E.2d, 1364 at 1371.

[68] Transcript VII: 45-62.

178. Under the general language of Count I of its Petition, *Union* contends that Regulation 47, taken as a whole, is *in excess of the Commissioner's regulatory powers* under the statutes and that it should therefore be declared invalid and unenforceable in its entirety.

179. Although this Count sweeps with a broad broom, in the presentation of its evidence *Union* appears to have confined its attack to subsection 47.07(1) relating to specified disease policies, subsection 47.07(2) relating to medicare supplement policies, and subsection 47.09(4) relating to the setting of minimum loss ratios. During the trial of the action *Union* explained that its challenge to the medicare supplement provisions dealt only with the issue of notice and did not address the substantive provisions of 47.09(2). As to the latter, all parties stipulated accordingly.[69]

180. Subsections 47.07(1) and 47.07(2) have already been discussed above. Subsection 47.09(4) of Regulation 47 states that any rate schedule filed with the Division will be disapproved unless the aggregate anticipated loss ratios filed with the rate schedule under 47.09(3) meet certain minimum percentage requirements. These are not mere matters of form but go close to the heart of the substance of the policies. As with the rest of Regulation 47, this subsection has as retroactive as well as prospective application. It is intended to apply to policy forms currently on the market which have already received certification under section 108 as well as to future filings. Although subsection 47.09(5) gives an aggrieved insurer a right to a hearing before the Commissioner, no provision is made to safeguard its rights to an adjudicatory hearing and judicial review under subsections 8A, B, and C of section 108. Quite clearly the Commissioner's view that Regulation 47 overrides the provisions of c. 175, § 108 imperils the due process rights of the petitioners and other parties similarly situated.

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[69] Transcript V: 36-39.

181. In the judgment of the Court, and for the reasons outlined in preceding portions of this Opinion relative to the validity of subsection 47.07(1), subsection 47.09(4) exceeds the regulatory powers of the Commissioner since in conflict with the provisions of section 108 which entitle an insurer to an adjudicatory hearing and a right of judicial review in any case where withdrawal of a prior approval is attempted.

182. As in the case of Union's Count X, the Court does not read its Count I as alleging that the substantive provisions of subsection 47.09(4) are arbitrary or capricious, or that it is unsupported by evidence introduced during the trial of this action. Hence no ruling need be made in that regard.

* * *

183. In their Petitions both *American* and *Union* contend that the provisions of Regulation 47 and the Commissioner's practices thereunder which effectively bar their right to market specified disease policies in Massachusetts unconstitutionally deprive them of their right to *equal protection under the law* and should therefore be declared invalid and unenforceable.[70] Additionally *Union* contends that the regulation provisions impairing the sale of medicare supplement policies violate its right to equal protection.[71]

184. The Court understands the petitioners to say that the imposition of stringent regulations controlling the sale of specified disease policies and medicare supplement policies only on the writers of individual insurance policies and not on those engaged in the sale of group insurance is discriminatory in nature and in derogation of equal protection of the law.[72] It is noted that subsection 47.02 of Regulation 47 states that the regulation shall apply to "all individual accident and sickness insurance policies," and that it goes on to make clear that group policies are not involved.

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[70] American Complaint ¶ 15; Union Complaint Count XI.

[71] Union Complaint XI.

[72] The Court infers from this argument that Regulation 47 has no counterpart in the field of group insurance.

185. The Commissioner's regulatory authority over group insurers comes under c. 175, §110, whereas his control over non-group insurers is derived from sections 108 and 110E. Although the petitioners do not go so far as to say that a statutory distinction may not be made between the two classes of insurers where reasonably related to a legitimate and defensible public purpose, and while they concede that the Commissioner may independently regulate each class within reasonable limits, they stress that his right do so cannot be stretched, as in this case, to limit the sale of one type of insurance to one class of insurers and not the others. This they say would contravene the intent of the statutes, pointing out that an examination of the entire regulatory scheme governing the insurance industry manifests a clear public interest in maintaining a competitive relationship among insurers of the ultimate benefit of the consumer. *Mass. Assoc. of Independent Insurance Agents and Brokers v. Comm. of Insurance*, 373 Mass. 290, 367 N.E.2d 796, 800 (1977).

186. The petitioners further argue that the economic and 'competitive' injury which has or can result from the enactment of Regulation 47 militates against these important public policies, that it imposes an unreasonable and unfair burden on the petitioners as competitors in the marketplace, and that it therefore denies them equal protection of the law. The Court does not agree.

187. To survive a constitutional challenge under the 'equal protection' doctrine it need only be shown that the classification under attack can be held to rationally further a legitimate governmental purpose. Legislative discretion is limited only to the extent of forbidding arbitrary or irrational classifications. In areas of practical administration, rough accommodations that to some extent may result in a disparity of treatment can be justified and in some instances actually required. *Commonwealth v. Henry's Drywall Co., Inc.*, 366 Mass. 539, 320 N.E.2d 911 (1974); *Consolidated Cigar v.*

Dept. of Public Health, 372 Mass. 844, 364 N.E.2d, 1202 (1977).

188. When legislative authority is exerted in any given area it need not embrace every conceivable problem in that field in one fell swoop. The enacting body may proceed one step at a time, addressing itself at each step to that phase of the overall problem that seems most acute at the time. *Mobil Oil Corp. v. Attorney General*, 361 Mass. 401, 280 N.E.2d, 417 (1972). *Purity Supreme Inc. v. Attorney General*, 80 Mass. Ad. Sh. 1349, 407 N.E.2d, 297, 308 (1980).

189. The classification wrought into being by legislative enactment need not always be that which would commend itself to an outsider as a perfect solution. The legislative agency has broad discretion in determining how to approach its task. *Opinion of the Justices*, 368 Mass. 857, 333 N.E.2d, 414 (1975).

190. In the judgment of the Court the petitioners have not demonstrated in the trial of this action that the imposition of Regulation 47 on the sale and issuance of individual accident and sickness insurance policies while exempting group policies from the impact of the regulation, is so invidious or irrational a classification that it violates the rights of the petitioners to equal treatment under law.

ORDER

On the basis of the foregoing findings of fact and conclusions of law, it is hereby ORDERED:

1. That subsection 47.07(1), subparts (a) through (e) inclusive, of Regulation 47 of the Massachusetts Commissioner of Insurance [211 CMR 47.07(1)(a)-(e)] is declared invalid, void, and unenforceable.
2. That subsection 47.09(4), subparts (a) through (c) inclusive, or Regulation 47 of the Massachusetts Commissioner of Insurance [211 CMR 47.09(4)(a)-(c)] is declared invalid, void, and unenforceable.

3. That the Commissioner of the Massachusetts Division of Insurance may not withhold or withdraw approval of accident and sickness insurance policy forms as defined in G.L. c. 175, § 108, paragraph 1, without first giving an insurance carrier aggrieved by such action all rights to notice, hearing, and judicial review as set forth in said section 108, the terms of G.L. c. 175, § 110E and Regulation 47 to the contrary notwithstanding.
4. That any action taken by the Commissioner prior to the date of entry of final judgment in this action which purported to withhold or withdraw approval of said insurance forms on the basis of the Commissioner's Regulation 47, sections 47.07(1) or 47.09(4) without first giving an insurance carrier affected thereby all rights to notice, hearing, and judicial review as set forth in section 108, is now adjudicated to be null and void and shall be set aside.
5. All provisions of the Commissioner's Regulation 47 [211 CMR 47] not expressly declared invalid and void under this ORDER shall remain in full force and effect.

_____

Matthew R. McCann, J.

ENTERED:_____

Commonwealth of Massachusetts
Superior Court Department of the Trial Court

SUFFOLK, SS.

AMERICAN FAMILY LIFE ASSURANCE CO.

v.

MICHAEL SABBAGH,
COMMISSIONER OF INSURANCE
Civil Action No. 37921

JUDGMENT ON FINDINGS BY THE COURT

May 21, 1982

THIS ACTION CAME ON FOR HEARING BEFORE THE COURT, McCANN, J., PRESIDING, AND THE ISSUES HAVE BEEN DULY HEARD AND FINDINGS HAVING BEEN DULY RENDERED: IT IS ORDERED AND ADJUDGED AS FOLLOWS:

1. That subsection 47.07(1), subparts (a) through (e) inclusive, of Regulation 47 of the Massachusetts Commissioner of Insurance (211 CMR 47.07(1)(a)-(e)) is declared invalid, void, and unenforceable.
2. That subsection 47.09(4), subparts (a) through (c) inclusive, of Regulation 47 of the Massachusetts Commissioner of Insurance (211 CMR 47.09(4)(a)-(c)) is declared invalid, void and unenforceable.
3. That the Commissioner of the Massachusetts Division of Insurance may not withhold or withdraw approval of accident and sickness insurance policy forms as defined in

G.L. c. 175, § 108, ¶ 1, without first giving an insurance carrier aggrieved by such action all rights to notice, hearing, and judicial review as set forth in said section 108, the terms of G.L. c. 175, § 110E and Regulation 47 to the contrary notwithstanding.

4. That any action taken by the Commissioner prior to the date of entry of final judgment in this action which purported to withhold or withdraw approval of said insurance forms on the basis of the Commissioner's Regulation 47, sections 47.07 (1) or 47.09 (4) without first giving an insurance carrier affected thereby all rights to notice, hearing, and judicial review as set forth in section 108, is now adjudicated to be null and void and shall be set aside.
5. All provisions of the Commissioner's Regulation 47 (211 CMR 47) not expressly declared invalid and void under this ORDER shall remain in full force and effect.

DATED AT BOSTON, MASSACHUSETTS, THIS 20TH DAY OF MAY 1982

Form of Judgment Approved:
Matthew R. McCann, J.
Justice of the Superior Court Department

Michael Joseph Donovan
Clerk of Court

By: Kevin [Murphy]
Assistant Clerk

JUDGMENT ENTERED ON DOCKET MAY 21, 1982 PURSUANT TO THE PROVISIONS OF MASS. R. CIV. P. 53(a) AND NOTICE SENT TO PARTIES PURSUANT TO THE PROVISIONS OF MASS. R. CIV. P. 77(d).

Appendix B

Supreme Judicial Court

S-2971

AMERICAN FAMILY LIFE ASSURANCE COMPANY

vs.

COMMISSIONER OF INSURANCE
(and a companion case[1]).

HENNESSEY, C.J. The defendant, the Commissioner of Insurance (Commissioner), appeals from two Superior Court judgments invalidating regulations promulgated by the Commissioner. The regulations, codified at 211 Code Mass. Regs. 47.07(1)(a)-(e) and 47.09(4)(a)-(c) (1980), effectively banned the sale of individual health insurance policies covering only one or a few diseases (specified disease insurance), unless they covered twelve listed diseases and met certain other requirements. The regulations were intended to curb abuses relating to the sale of cancer-risk insurance, which the Commissioner found was a poor health care investment, and was being marketed in an unscrupulous manner. The plaintiffs, American Family Life Assurance Company (American), and Union Fidelity Life Insurance Company (Union), had been selling cancer-risk insurance. They challenged the validity of the regulations in the Superior Court pursuant to G.L. c. 30A, § 7, and G.L. c. 231A, § 2. The cases were consolidated for trial. A Superior Court judge concluded that the Commissioner lacked statutory authority to promulgate the regulations, and that portions of the regulations were arbitrary and capricious. Judgments were entered accordingly. The case is before us on direct appellate review. We reverse.

[1] Union Fidelity Life Insurance Company *vs.* Commissioner of Insurance.

The judge found the following facts. Under prior regulations, American and Union had been selling cancer-risk insurance policies which had been approved by the Commissioner pursuant to standard procedures for the approval of insurance policies under G.L. c. 175, § 108. In 1979, the Commissioner promulgated a regulation entitled "Rules and Regulations Governing Individual Accident and Sickness Insurance," later codified as 211 Code Mass. Regs. 47.00 (1980).[2] The regulations dealt with a variety of matters, but the provisions at issue here are those governing the sale of specified disease insurance. In brief, they established five requirements: Under 47.07(1)(a), specified disease insurance has a maximum benefit limit of no less than $10,000 and covers all twelve specified conditions (one of which is cancer); under 47.07(1)(b), internal limits on dollar benefits can be no less than certain designated amounts; under 47.07(1)(c), specified disease coverage shall be guaranteed renewable to age sixty-five and may not be sold to anyone over that age; under 47.07(1)(d), it may be sold only as a supplement to basic hospital insurance; and under 47.09(4)(a)-(c), rates charged must meet specified minimum loss ratios.

The regulations apply to "all individual ... sickness insurance policies ... filed with the Division of Insurance, delivered, or issued for delivery after the effective dates of this regulation.... No policy ... covered by this regulation shall be issued or issued for delivery unless it complies with this regulation." 211 Code Mass. Regs. 47.02 (1980). The regulations were to be effective upon publication, which occurred on September 27, 1979. The Commissioner does not contend that the regulations apply to policies which were issued before that date. However, because there is no saving clause in the regulations, the Commissioner has deemed the regulations to apply to new sales of previously approved specified disease policies. Thus, under the regulations, American's and Union's previously approved cancer-risk insurance policies cannot be issued to new purchasers.

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[2] The judge found that all parties agreed that these regulations were developed through a rule-making proceeding.

The judge concluded that regulations 47.07(1)(a)-(e) and 47.09(4)(a)-(c), exceeded the Commissioner's statutory authority. The judge discussed the statutes relied on to support the Commissioner's authority to promulgate the regulations, and concluded that the only possible basis was G.L. c. 175, § 110E.[3] Furthermore, even assuming that the Commissioner had authority to promulgate the regulations, the judge concluded that regulations 47.07(1)(a) and (d) were arbitrary and capricious, because they had no rational relation to the goals of § 110E. Finally, the judge concluded that the Commissioner could not withdraw his approval of previously approved policies for noncompliance with the new regulations without first affording the affected insurers an adjudicatory hearing.

We are presented with three questions on this appeal. First, did the Commissioner have statutory authority to promulgate regulations 47.07(1)(a)-(e) and 47.09(4)(a)-(c) under G.L. c. 175, § 110E?[4] Second, were regulations 47.07(1)(a) and (d) arbitrary and capricious? Third, was the Commissioner required by statute or by constitutional due process to hold an adjudicatory hearing before withdrawing approval of a previously approved policy under G.L. c. 175 § 110E?

1. We first consider the scope of the Commissioner's authority under G.L. c. 175, § 110E, inserted by St. 1973, c. 1081. It provides in relevant part: "The commissioner shall make rules and regulations . . . to establish minimum standards of full and fair disclosure, for the form and content of policies of accident and sickness insurance.... Such rules and regulations may apply to all, any portion or reasonable classifications of such policies or contracts, and shall be made to bring about: (a) reasonable standardization and simplifica-

[3] The regulations state that they are promulgated under the authority of G.L. c. 175, §§ 2B, 108, 110E; c. 176, § 26; c. 176A; c. 176B; and c. 176E.

[4] Because, as will be seen, we discern sufficient authority of the Commissioner in § 110E, we need not look to other possible statutory bases.

tion of coverages to facilitate understanding and comparisons; (b) elimination of provisions which may be misleading or unreasonably confusing, in connection either with the purchase of such insurance or with the settlement of claims; (c) elimination of deceptive practices in connection with the sale of such insurance; (d) elimination of provisions which may be contrary to the health care needs of the public; (e) elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders thereof."

The plaintiffs argue that the phrase "full and fair disclosure, for the form and content of policies, "limits the Commissioner's authority to issue regulations aimed at ensuring full and fair disclosure. They rely chiefly on the use of the word "for," and on the legislative history of § 110E. The Superior Court judge agreed that "[u]nder a literal reading of the statute," the Commissioner's power under § 110E was limited to establishing minimum standards of full and fair disclosure. The objectives (a) through (e) were subordinate to this dominant purpose. The judge found that the legislative history of § 110E supported this interpretation. Accordingly, he held that the challenged regulations exceeded the Commissioner's authority because they governed substantive provisions of accident policies unrelated to standards of disclosure, such as the risks to be insured against, the minimum benefits to be provided and the length of time during which said benefits must be available.

Section 110E was inserted by St. 1973, c. 1081. In the 1973 legislative session the Division of Insurance recommended the passage of House Bill No. 109 which would have amended G.L. c. 175, § 108, by adding a new final paragraph providing in part that "[t]he Commissioner may also by regulation establish minimum benefits for accident or sickness policies . . . so as to prevent the sale of policies that he finds are not of substantial economic value to the policyholder." Later in the same session, House Bill No. 7319 was introduced. It em-

powered the Commissioner to "make ... reasonable rules and regulations,... including standards of full and fair disclosure, for the form and content of policies of accident and sickness insurance." This bill was amended by Senate Doc. No. 1903, which substituted the present language of this portion of § 110E, authorizing the Commissioner to make "regulations ... to establish minimum standards of full and fair disclosure, for the form and content of policies." The plaintiffs contend that the changes in language from these prior bills to § 110E as enacted reveal a legislative intent to limit the Commissioner's authority to the promulgation of regulations governing disclosure.

Although the plaintiffs' interpretation of this portion of the statute is not unreasonable, the Commissioner advances an alternative view. He suggests that since the words "for the form and content of policies" are separated from the words "to establish minimum standards of full and fair disclosure" by a comma, each phrase "was intended to be a parallel and independent source of regulatory authority." Thus, the Commissioner is empowered to make regulations concerning the content of insurance policies, consistent with the listed statutory goals, unrelated to disclosure.

We agree with the Commissioner's interpretation, primarily because the plaintiffs' construction is at odds with a workable reading of the entire statute. "Where the draftsmanship of a statute is faulty or lacks precision, it is our duty to give the statute a reasonable construction." *School Comm. of Greenfield v. Greenfield Educ. Ass'n,* 385 Mass. 70, 79-80 (1982). *Massachusetts Comm'n Against Discrimination v. Liberty Mut. Ins. Co.,* 371 Mass. 186, 190 (1976). *Massachusetts Turnpike Auth. v. Commonwealth,* 347 Mass. 524, 528 (1968). We will not construe the statutory language so that it is inconsistent with other portions of § 110E when the language can fairly be interpreted to lead to a logical and consistent result. *Lexington v. Bedford,* 378 Mass. 562, 570 (1979). See *Boston v. Massachusetts Bay Transp. Auth.,* 373 Mass. 819, 823 (1977). Section 110E authorizes regulation

of the content of policies to achieve the elimination of provisions which are contrary to the health care needs of the public and the elimination of coverages so limited in scope as to be of no substantial economic value. G.L. c. 175, § 110E(*d*), (*e*). It is unlikely that the Legislature considered it could eliminate undesirable provisions and coverages by regulating disclosure. Such regulations at best might indirectly help to achieve these goals in the long run. We conclude that the specific statutory mandate in § 110E for elimination of coverages and provisions, indicates a legislative intent to empower the Commissioner to make regulations to effectuate these goals directly. Cf. *Cody v. Connecticut Gen. Life Ins. Co.*, 387 Mass. 142, 148 (1982) (public policy of Commonwealth, one source of which is G.L. c. 175, § 110E, is that insurance contracts may not be misleading, and that coverages may not be unrealistically limited or so limited in scope as to be of no substantial economic value).

The Commissioner notes that the act which created § 110E, St. 1973, c. 1081, was entitled, "An Act further regulating the contents of accident and sickness policies and regulating advertising of such policies." The title speaks of regulation of the content of policies, but does not mention disclosure. It is well established that, although the title of an act cannot control the plain provisions of the act, it may aid construction of ambiguous clauses. *Breault v. Ford Motor Co.*, 364 Mass. 352, 353-354 n.2 (1973). *Commonwealth v. Jarrett*, 359 Mass. 491, 495 n.5 (1971). *Massachusetts Soc'y for the Prevention of Cruelty to Animals v. Commissioner of Pub. Health*, 339 Mass. 216, 223 (1959). Similarly, the Governor's message which accompanied enactment of St. 1973, c. 1081, declared: "It is essential that the provisions of this Act take effect forthwith in order that the Commissioner of Insurance may immediately make regulations concerning the advertising *and content* of accident and sickness insurance policies" (emphasis supplied). St. 1973, c. 1081, at 1142-1143.

Moreover, the Commissioner's contemporaneous, long-continued construction of § 110E supports our interpreta-

tion. "The interpretation of the Commissioner is not binding on us, but is entitled to some weight . . . and the consistent administrative construction of a statute permitting more than one possible interpretation is of added significance" (citations omitted). *Metropolitan Property & Liab. Ins. Co. v. Commissioner of Ins.*, Mass. Adv. Sh. (1981) 347, 356. See *Lowell Gas Co. v. Commissioner of Corps. & Taxation*, 377 Mass. 255, 262 (1979); *Casa Loma, Inc. v. Alcoholic Beverages Control Comm'n*, 377 Mass. 231, 235 (1979); *Maryland Cas. Co. v. Commissioner of Ins.*, 372 Mass. 554, 563 (1977); *Cleary v. Cardullo's, Inc.*, 347 Mass. 337, 343 (1964). Regulations are good indicators of an agency's interpretation of a statute it is charged with administering. In 1974, shortly after § 110E was enacted, the Commissioner promulgated regulations which were subsequently codified at 211 Code Mass. Regs. 42 (1978). These were the predecessor regulations to the regulations now codified at 211 Code Mass. Regs. 47 (1980), at issue in this case. They allowed insurers to issue policies which covered only one disease, but required, inter alia, that such policies have a maximum benefit level of no less than $10,000, meet specified internal limits on dollar benefits, and be noncancellable for life without right to raise the premium rate. 211 Code Mass. Regs. 42.12, 42.05 (19) & (20) (1978). These regulations established coverages for individual sickness insurance policies. They reveal that from the time § 110E was enacted, the Commissioner considered that the statute authorized him to make such regulations. The challenged regulations are consistent with the Commissioner's contemporaneous interpretation as indicated by the 1974 regulations.

We conclude that § 110E empowered the Commissioner to regulate the content of insurance policies to achieve the listed goals. Regulations 47.07(1)(a)-(d) and 47.09(4)(a)-(c) were accordingly within the Commissioner's statutory authority.

2. The judge found that regulations 47.07(1)(a) and (d) were arbitrary and capricious. The judge considered the relation-

ship between the regulations and § 110E(*d*) and (*e*). He focused on the twelve-disease requirement of 47.07(1)(a), and concluded on the basis of the evidence at trial that there was no rational basis for the twelve-disease classification from the standpoint of economic value, health care, the catastrophic illness test, frequency of occurrence, medical cost or severity. Similarly, he concluded that the supplement requirement of regulation 47.07(1)(d) was arbitrary, capricious, and unreasonable.

As a threshold matter, we note that there appears to be some confusion among the parties as to the difference between a challenge to a regulation in practice and on its face, and the proper standard of our review of the Superior Court judgment. The plaintiffs argue that because they produced evidence at trial, they attacked regulations 47.07(1)(a) and (d) as arbitrary and capricious in practice, and we should review the judge's decision under the clearly erroneous standard. If the regulations exceeded the Commissioner's statutory authority, then they would be arbitrary and capricious on their face in that they would by definition be unrelated to the achievement of any statutory goals. Here the judge found that, even assuming the Commissioner was empowered to promulgate the regulations, they were not rationally related to the goals of § 110E. His conclusion was certainly based on evidence the plaintiffs produced at trial. However, this was still an analysis of the facial validity of regulations 47.07(1)(a) and (d). The plaintiffs' evidence tended to show that specified disease insurance is useful and economical for some individuals, and that the twelve-disease requirement of regulation 47.07(1)(a) is not a rational grouping based on economic value, health care value, the catastrophic illness test, frequency of occurrence, medical severity and medical cost. In particular, the plaintiffs argued that the Commissioner's reliance on the Blue Cross-Blue Shield Prolonged Illness Certificate (PIC), to develop the twelve-disease list, had no real validity. All of these arguments go to the question whether regulation 47.07(1)(a) itself is arbitrary and capricious.

It is, therefore, clear that the plaintiffs challenged, and still challenge, the facial validity of the regulations.[5] The fact that the judge's conclusion on the relation of the regulations to the statutory goals was based on trial testimony, rather than statutory analysis, does not change the fact that he was deciding a challenge to the rationality of the regulations themselves, not a challenge based on their effects in operation.

We have concluded that § 110E empowered the Commissioner to regulate the content of policies to achieve the listed statutory goals. Under well established principles, if regulations 47.07(1)(a) and (d) are rationally related to these statutory goals, they will be upheld. "We accord to a regulation . . . the same deference we extend to a statute." *Massachusetts State Pharmaceutical Ass'n v. Rate Setting Comm'n*, 387 Mass. 122, 127 (1982), citing *Greenleaf Fin. Co. v. Small Loans Regulatory Bd.*, 377 Mass. 282, 293-294 (1979). *Purity Supreme, Inc. v. Attorney Gen.*, Mass. Adv. Sh. (1980) 1349, 1355. "Thus, we must apply all rational presumptions in favor of the validity of the administrative action and not declare it void unless its provisions cannot by any reasonable construction be interpreted in harmony with the legislative mandate." *Consolidated Cigar Corp. v. Department of Pub. Health*, 372 Mass. 844, 855 (1977). *Purity Supreme, Inc. v. Attorney Gen., supra* at 1362. We will not substitute our judgment as to the need for a regulation, or the propriety of the means chosen to implement the statutory goals, for that of the agency, so long as the regulation is rationally related to those goals. "It is not our function to consider the expedience of an enactment or the wisdom of its provisions." *Commonwealth v. Henry's Drywall Co.*, 366

[5] The plaintiffs' only claim that regulation 47.07(1)(a) was illegal in practice was based on the disapproval of a chemotherapy rider submitted by the Physicians Mutual Insurance Co., which is not a party to this action. The plaintiffs lack standing to raise this issue. In any event, if the disapproval was illegal, the remedy would be to order approval of the rider, not to invalidate the regulation. See *Massachusetts State Pharmaceutical Ass'n v. Rate Setting Comm'n*, 387 Mass. 122, 135 (1982).

Mass. 539, 544 (1974). Accordingly, a statute or a regulation is not invalid "merely because the evidence of record suggests that the 'ultimate efficacy' of achieving the statutory purpose is in question, or that the means to achieve the statutory end is rough, illogical or not the best available. . . ." *Shell Oil Co. v. Revere*, Mass. Adv. Sh. (1981) 1285, 1290. Rather, a plaintiff challenging a regulation as arbitrary and capricious bears the heavy burden of "proving on the record 'the absence of any conceivable ground upon which (the rule) may be upheld.' " *Purity Supreme, Inc. v. Atttorney Gen., supra* at 1363, quoting *Colella v. State Racing Comm'n*, 360 Mass. 152, 156 (1971). *Commonwealth v. Henry's Drywall Co., supra* at 542. *Druzik v. Board of Health of Haverhill*, 324 Mass. 129, 138 (1949). See *Shell Oil Co. v. Revere, supra* at 1291 (if question is at least debatable or arguable, legislation will be upheld).

Applying these principles to the instant case, we conclude that the plaintiffs did not carry their burden. The Commissioner's opinion indicates that the twelve-disease requirement of regulation 47.07(1)(a) was intended to curb abuses in the sale of cancer-risk insurance, including sales tactics exploiting public fear of the disease, and poor health care value. There was ample testimony before the Commissioner documenting these abuses. The Commissioner might well have determined that these abuses would be likely to occur in the sale of any specified disease insurance policy. It was, therefore, rational for him to take steps to eliminate the sale of insurance policies covering only one or a few diseases. Similarly, in light of evidence establishing the poor health care value of specified disease insurance, it was reasonable for him to prohibit the sale of such policies alone, by requiring in regulation 47.07(1)(d) that they be sold only as a supplement to basic hospital insurance.[6]

[6] We note that we are, of course, free to consider the evidence before the Commissioner, as well as any other relevant information, including that provided in the briefs, in determining whether there was a rational basis for the Commissioner's regulations.

The proposed regulation 47.07(1)(a) would have required specified disease insurance to cover all conditions of similar severity and cost as cancer. The Commissioner considered this definition too ambiguous, and found that the twelve-disease list based on the Blue Cross-Blue Shield PIC was an acceptable alternative. This was eminently reasonable. It was established at trial that the PIC was issued in 1954, based in part on information gathered from physicians, nursing home operators, and the caseload records of visiting nurses, and still existed in the same basic form until 1979. The fact that Blue Cross-Blue Shield no longer marketed the PIC due to other provisions of regulation 47.07(1)—principally the minimum benefits requirements—was not relevant to its rationality as a basis for the twelve-disease list in regulation 47.07(1)(a).

The plaintiffs' evidence at most established that there was a difference of opinion among medical and insurance experts as to the utility of specified disease insurance, and the practicality and reasonableness of the requirements of regulations 47.07(1)(a) and (d). Their evidence did not establish that the regulations lacked any conceivable basis. The plaintiffs did not even address the Commissioner's conclusion that regulation 47.07(1)(a) was necessary to curb marketing abuses in the sale of cancer insurance. We also note that in invalidating regulation 47.07(1)(d), the judge relied on evidence that the regulation would make specified disease insurance difficult to market, so that "[f]or all practical purposes, the free-standing specified disease policy will be a thing of the past." This was not relevant to show that regulation 47.07(1)(d) lacked a rational basis, but rather amounted to a disagreement by the judge with the Commissioner's judg-

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Massachusetts State Pharmaceutical Ass'n v. Rate Setting Comm'n, 387 Mass. 122, 126 (1982), and *Grocery Mfrs. of America, Inc. v. Department of Pub. Health*, 379 Mass. 70, 81 (1979), are not authority to the contrary. These cases establish that a *plaintiff challenging* regulations must prove its case in judicial proceedings, and may not rely on material submitted to an agency. They do not limit judicial consideration of the bases upon which the Commissioner may have relied in promulgating the regulations.

ment that such policies were detrimental to the public's health care needs.

As we have emphasized, judicial review of regulations should not become a de novo trial in which the trial judge decides whether a challenged regulation is reasonable based on the evidence presented. Absent some other illegality, the scope of review is limited to the question whether the plaintiff has established that there is no conceivable basis on which the agency could have relied, not whether the plaintiff has shown that the regulations are not supported by other evidence, no matter how substantial. This deference is necessary to ensure that courts do not interfere with the separation of powers between the Legislature and the judiciary by substituting their judgment for that of the agency charged with the administration of the legislative mandate. See *Shell Oil Co. v. Revere, supra* at 1291.

We conclude that regulations 47.07(1)(a) and (d) are not arbitrary and capricious. In light of the foregoing, we need not address the Commissioner's other objections to the conduct of the trial.

3. Finally, we consider the judge's ruling that the Commissioner could not withdraw his approval of new sales of American's and Union's previously approved cancer-risk insurance policies without an adjudicatory hearing. We emphasize that the disputed regulations do not attempt to rescind policies already sold, but merely withdraw approval of future sales to new purchasers of previously approved policies.[7] Section 110E provides: "When a rule or regulation has been adopted pursuant to this section and an individual policy of . . . sickness insurance form regulated by [§ 108] is not in compliance with such rule or regulation, such noncompliance shall be grounds for a withdrawal of approval of such policy form and the commissioner may withdraw his approval of any such form upon written notice to the insurer

[7] In his brief, the Commissioner noted that "[e]xisting insurance contracts remained in force and renewals of such existing contracts were not prohibited by . . . any . . . regulation."

specifying his reasons therefor." The plain language of the statute authorizes the Commissioner to withdraw approval "upon written notice to the insurer." This is the procedure which the Commissioner considers is to be followed in withdrawing approval of previously approved policies which do not comply with the new regulations.

The plaintiffs argue that § 110E should not be treated as authorizing regulations under which the Commissioner may withhold approval of policies, or withdraw approval of policies previously cleared by this office under c. 175, § 108, without first granting the insurer an adjudicatory hearing and a right of judicial review, as spelled out in § 108.[8] The judge agreed, relying on a perceived linkage between §§ 108 and 110E. Accordingly, the judge concluded that the "Commissioner is unwarranted in holding that previously approved health ... policies, which do not now comply with the requirements of ... [the regulations] ... may be condemned for further sale or use without first offering the affected insurer the due process rights spelled out in section 108, and that any action he may have taken thus far to revoke the good standing of such policies would do violence to rights of constitutional due process and should be declared null and void."

General Laws c. 175, § 108, is the basic statute applicable to the delivery or issuance of individual accident and sickness insurance policies. The statute authorizes the delivery and issuance of a health and accident policy if approved by the Commissioner. If no action is taken within thirty days of the filing of the policy form with the Commissioner, the form is deemed to be approved. Once a policy form is approved, it cannot be disallowed for further use unless the disllowance follows the procedural steps outlined in subsections 8 B, and C, which include notice, an adjudicatory hearing, and judicial review under G.L. c. 30A, § 14(8).

The plaintiffs base their argument on the reference to § 108 in § 110E, and on the legislative history of § 110E. An earlier draft of this portion of § 110E stated that when a policy is not in compliance with a regulation adopted under § 110E, it

[8] On this procedural ground, Union also objected to portions of the regulations governing Medicare supplement insurance.

"shall . . . be deemed to be disapproved as of a date specified in such regulation not less than sixty days following its effective date, without any further or additional notice other than the adoption of the regulation." The plaintiffs contend that the change from "deemed to be disapproved" to "grounds for a withdrawal" shows a legislative intent to require compliance with § 108, 8 B, which speaks of "withdrawal of approval."

Apart from the plain language of § 110E, the short answer to the plaintiffs' claim is that § 108, 8 A, B and C, governs curative, adjudicative proceedings, while § 110E establishes a procedure for preventative, rule-making activity. It is undisputed that the regulations were rules. In addition, the plaintiffs' arguments lack merit. The reference in § 110E to § 108 merely defines the type of policies regulated by § 110E. The change in language from the earlier to the final draft appears to us to reflect a legislative intent to provide an insurer with notice that it is no longer in compliance with the law, so that it will not be caught unaware. A contrary interpretation would frustrate the very purpose of effective agency rulemaking, by requiring the Commissioner to comply with the more cumbersome adjudicatory procedures in order to put his rules into effect. We conclude that § 110E does not require the Commissioner to hold an adjudicatory hearing before withdrawing approval of future sales of policies for noncompliance with the new regulations.[9]

Nor do constitutional principles require an adjudicatory hearing in these circumstances. The plaintiffs' interest is in future sales to new purchasers of previously approved policies. This is not a property interest the deprivation of which requires a hearing to satisfy due process. See *Pronghorn, Inc. v. Licensing Bd. of Peabody*, 13 Mass. App. Ct. 70, 72-73 (1982). 430 N.E.2d 842.

The judgments are reversed and judgments shall be entered declaring that the regulations here in issue are valid.

So ordered.

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[9] In light of our holding, we do not address the Commissioner's claim that the so-called readability statute, G.L. c. 175, § 2B, authorizes the Commissioner to withdraw approval without a hearing of policies which do not comply with the new regulations.